# Innovations in Controlling Statewide Health Costs



Center for Policy Research
Office of Research Studies
National Governors' Association

In response to requests from Governors for information to assist them in curbing health care costs, the National Governors' Association Center for Policy Research, Office of Research Studies conducted a survey of cost containment strategies currently in use or proposed in each state. The questionnaire was designed to gather information on state strategies for containing health care costs through changes in law, regulation, program administration and demonstration projects. The survey results are compiled in two documents, one dealing with with state Medicaid initiatives, and the second dealing with other state health progams. A third publication, detailing state options for Medicaid cost containment, was also prepared as part of the Center's project. Partial support for the activities was provided by the Health Care Financing Administration under Grant #18-P-7490/3-01. We would like to give special thanks to Dorrett Lyttle, Janice Webb, John Steel, Kathleen Sullivan, Kendra Mahoney, Virender Manocha and Beverly Smith for their significant contributions to the data collections and analysis, and preparation of the project publications. Appreciation is also due to Jan Kary for coordinating the national conferences.

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Errata Sheet

Page 7, paragraph 1, line 3 should read as follows:

"The assessment and allocation of manpower resources (both physician and nonphysician), the relationship between planning and reimbursement policy, and facility management and coordination have been virtually ignored in health planning."

Page 13, paragraph 5 should read as follows:

"Licensing and certification in the health field originally was designed to assure quality of care. It has become an effective tool for encouraging or discouraging the development of new professions. The decision to license, register, certify, or in some other fashion enable the physician assistant or nurse practitioner to practice is entirely a state decision; this decision should be based on the state's need to improve access to primary care and the potential cost-effectiveness of the practitioner. In addition to the licensing decision, the state must also determine the conditions of practice, educational requirements, and regulations concerning administration, dispensing, and prescription of drugs. An adequate level of education and appropriate examination are necessary to assure the capability of those providing primary care. However, once the education requirements become excessive and inflexible, and the examination becomes overly extensive, the basic purpose of having adequately trained personnel for cost efficient health care delivery in underserved areas is defeated."

Page 14, paragraph 4, should read as follows:

"The NGA survey asked for state policy on each of these issues as they pertain to four categories of allied health professions. Forty-six states responded to this section. In the majority of states which license FNPs, the State Board of Nursing was the regulating agency. The State Board of Medical Examiners is the regulating agency for the majority of states which license PAs. For both PAs and family nurse practitioners the most frequently chosen physician supervision requirements were supervision by written protocol or telecommunications. Similarly, for both PAs and FNPs the most frequent response to drug handling and prescription requirements was the provision of some administering, dispensing and prescribing authority."

Page 18, paragraph 2, line 3 should read as follows:

"The state role in lifestyle change or wellness programs, and the long range cost containment implications are not yet clear."

Page 18, paragraph 3 should read as follows:

"The multiple funding sources for prevention efforts at the state and federal level make it difficult to develop a comprehensive prevention strategy incorporating the traditional (i.e., communicable disease) and nontraditional (wellness) approaches."

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# INTRODUCTION

The issue of health care cost containment is not new. Numerous public and private efforts have been directed at controlling increases in prices, utilization and the expanding nature of health services themselves. Nevertheless, health care expenditures continue to account for a larger portion of private as well as public budgets. In 1979, 9 percent of this country's gross national product represented health outlays (HCFA, 1980). Between 1950 and 1977, the medical care component of the Consumer Price Index rose 43 percent faster than all nonmedical goods and services combined. Although the relative difference between increases in health care services and increases in all non-medical goods and services has become smaller, this is due more to increases in the overall rate of inflation rather than decreases in health care costs resulting from cost control measures.

The provision of unlimited health care for all people, whether through public or private funding, is rapidly becoming an unrealistic goal. While the situation is most critical in publicly funded programs, questions have been raised concerning the capacity of society as a whole to accept the financial consequences of certain medical procedures, even in the case of proven effectiveness. Whether or not such ethical judgements are eminent or the debate premature, it is clear that the importance of health care cost control has not diminished.

The National Governors' Association State Health Care Cost Containment Initiatives summarizes state efforts to control statewide health expenditures proposed or implemented through 1980. Eight areas are examined, some reflecting more traditional approaches, others innovative strategies. The information on state programs reported in this paper was provided by state officials in response to an NGA survey. The following survey sections were sent directly to appropriate state officials.

| | |
|---|---|
| o Health Care Cost Containment Coordination | Governors' Health Staff |
| o Hospital Rate-Setting and Budget Review | Human Resources Commissioners or Public Health Directors |
| o Insurance Regulation | Insurance Commissioners |
| o Health Planning | State Health Planning and Development Agency Directors |
| o Consumer Information | Attorney Generals |
| o Manpower | Statewide Health Manpower Coordinators |
| o Licensing and Certification of Facilities | Licensure and Certification Directors |

| | |
|---|---|
| o Alternatives to Institutionalization | Directors of Departments of Aging, Mental Health and Developmental Disabilities |
| o Prevention | Public Health Directors |

Project staff are indebted to these state officials for their time and assistance.

## HEALTH CARE COST CONTAINMENT COORDINATION

Within every state, several agencies have jurisdiction over programs which bear significantly on health care cost containment. The list of the state officials to whom survey sections were sent is a case in point. Coordination of efforts is difficult at best. The NGA survey asked each state whether a mechanism, person or agency has special responsibility for coordinating efforts. Forty-nine states responded to this section. Twenty-five states identified a coordination process specifically for health care cost containment. Forty states identified mechanisms for the coordination of health and welfare functions in general.

## HOSPITAL RATE SETTING AND BUDGET REVIEW

To date, debates concerning the appropriateness and effectiveness of cost control measures have centered on the competition and regulation argument. While there is universal acknowledgement that traditional economic market signals of supply and demand do not apply to the health care market, disagreement has focused on the relative benefit of regulatory versus competitive market strategies in containing health care costs.

Supporters of a competition theory believe that the most efficient way to restore economic efficiency to the health care market is to restructure market incentives and encourage competition among health providers. This approach has resulted in programs to improve consumer information, the promotion of health maintenance organizations, and the voluntary effort. Regulators dispute the efficacy of these approaches, at least in terms of their short run effects. Regulatory strategies include planning, discussed in a later section, and hospital rate-setting and budget review.

The regulatory versus competition distinction should serve as a reminder of the types of cost containment alternatives that are available, rather than as an absolute determinant of policy. Rigid adherence to either strategy may obscure the success of strategies at both ends of the continuum. In fact, hospital rate-setting programs, in those states where participation is mandatory, have demonstrated success in controlling the rate of increase in hospital costs relative to national performance (HCFA, 1980a).

Hospital rate-setting and/or budget review programs can differ on a number of dimensions, including whether the program is mandatory or voluntary, whether it sets rates or requires financial reporting or disclosure, the regulating agency (insurance department, independent commission, health department, etc.), and frequency of review. Programs also differ in the payors covered by the rates set, Blue Cross/Blue Shield, Medicaid, Commercial Carriers, etc. Most significantly, programs may vary in approach to the rate-setting process. The mechanism can set fixed rates for allowable charges or expenditures, or establish variable rates for charges or expenditures according to hospital characteristics.

Several reviews of hospital-rate setting programs to 1979 are available (HCFA; 1980a; Hereford, 1979). Consequently, the survey requested information from each state on the dimensions outlined above since 1979. Because of the uniqueness of each program they are discussed in the state abstracts for those states responding to this section (44 states).

The responsibility for regulating the insurance industry rests primarily with the states. The McCarran-Ferguson Act, enacted in 1945 in response to a Supreme Court decision holding that the insurance industry was not exempt from federal antitrust laws, provides that no act of Congress shall invalidate, supersede or impair any law enacted by any State for the purpose of regulating the insurance business. To the extent that the business is regulated by state laws, insurance is exempt from federal antitrust laws. The states regulate the industry generally through state departments of insurance, which are ordinarily empowered to perform the following functions:

- o approve licensing of insurers and agents
- o require submission and review of annual reports
- o implement statutory standards for policy content and notice
- o control rate setting in property and liability insurance through standards requiring rates be reasonable, adequate and nondiscriminatory, and rate setting in health insurance by requiring that premiums be reasonable in relation to benefits
- o set requirements for solvency, reserves and investment practices
- o apply the insurance laws through court orders, liquidations, receivership, cease and desist orders, injunctions, etc. (Insurance Regulation, 28 Drake Law Review, 762, 769 (1977).

In addition, state regulations applicable to ordinary commercial carriers are frequently different from those applied to Blue Cross and Blue Shield.

The latter generally operate under special enabling legislation exempting them from standard regulatory oversight, but submitting them to special structures.

States uniformly regulate health insurance contracts, which are agreements between two parties outlining the terms of the agreement and specifying the risks. The policy itself is the written manifestation of that agreement. Most states use the Uniform Individual Policy Provisions Law, recommended by the National Association of Insurance Commissioners, to ensure that the contracts contain no ambiguous or misleading language, and that the policy holder receives reasonable notice of the terms of the contract. (Markus & Hauch, State Regulation of Private Health Insurance, 1972). However, past studies indicate that few states require a "minimum benefits" standard designed to insure that an individual is not sold a policy which is so restrictive in coverage that it is unlikely that the purchaser will ever receive any benefits. (Markus and Hauch, 1972).

While states generally require insurors to submit information on rates charged, a few, if any, actually regulate the rates which may be set by commercial carriers even given the statutory authority to do so. It is argued that there is such intense competition within the health insurance industry itself for business that there is no need to regulate rates. Thus, states generally only require that there be a relationship between rates charged and benefits received, based on a "reasonableness" concept.

State regulations governing Blue Cross and Blue Shield differ from those applied to conventional commercial insurors. The greatest differences are in the regulations governing initial working capital, contingent reserves and rate setting. The Blues in many states were started with little or no financial resources and could not have operated if they had been required to comply with existing capitalization requirements. Although exempted from the capitalization requirements applied to commercial insurors, the interests of the company policyholders and creditors must be protected through various reserve requirements imposed on non-profit hospitals service corporations. Additionally, many states impose restrictions on total expenses either through limitations on acquisition costs, solicitation costs or by setting a percentage limit on overall increases. Most importantly, a number of states impose actual restrictions on subscriber rates, with review provisions, and a few impose restrictions on reimbursement rates. (Markus & Hauch, 1972).

The ability of the states, through their insurance commissioners, to regulate rates and benefits of Blue Cross/Blue Shield and other carriers is potentially a powerful tool for health care cost control. Insurance rate regulation or pressure can encourage third party carriers to in turn pressure hospitals and other providers with whom they have contracts to keep their costs under control. To the extent that the Blues contract with hospitals and physicians to reimburse them for services provided, they can exert a degree of leverage. The charge has been raised, however, that the close relationship between the boards of trustees of insurance companies and providers has inhibited such leverage. As a consequence, some states now attempt to guarantee adequate consumer representation.

As part of the NGA survey, states were asked to supply information on the power of the state Insurance Commissioner to approve benefit packages and premium rates, the composition or appointment to a Board of Trustees, Medigap benefits and cancer insurance. All fifty states responded to this survey section. Only three out of the fifty states do not require any type of approval of insurance carriers or HMOs. Forty-four of the fifty states require benefit package approval for at least one carrier, 38 require rate approval, 22 composition of the board, 41 medigap benefits, and 39 cancer insurance again for at least one carrier. For the latter two categories, the approval process in many states did not differ from policies generally.

Since the 1940's, state and federal efforts to improve access to health services and later to control the costs of health care have centered on requirements for the planned allocation of capital investment. These efforts have centered primarily on programs to control the construction and renovation of health care facilities, and have often been implemented without consideration for or attempts to coordinate with other needed forms of health planning. The assessment and allocation of manpower resources between planning and reimbursement policy have been virtually ignored in comprehensive health planning, physician and non-physician, and facility management and coordination. The emphasis on physical plan development in recent years has grown out of the concern that demand for health services arbitrarily expands to meet the survival needs of new or renovated facilities. To the extent that the states have ignored planning issues other than capital investment, they have lost valuable opportunities to control costs across the spectrum of health services.

Initially developed at the local level, when several major cities organized their resources to coordinate health facilities, the federal government became involved through the Hill-Burton construction program. Hospitals at the local level which met federal requirements for needs were rewarded with federal assistance. Implemented through a voluntary planning process, the program's limitations were apparent; while it could encourage voluntary planning with monetary incentives, it could not prohibit the construction of unneeded facilities. In 1964, New York State adopted the first "certification of need" program to permit a state agency to regulate the construction or expansion of all health facilities. The overwhelming majority of states now have CON programs, and these vary considerably in structure, function and effectiveness.

The lack of uniformity among CON laws across the nation reflects the make-up of economic and political factors within each state. The laws vary considerably by the types of facilities covered, the dollar cut-off for review, standards for reveiw, the structure of the review process and program sanctions. The following types of activities must be regulated by CON programs:

- investment in new plant and new beds
- investment in new services
- expenditures for renovation and equipment for existing support services.

Most certificate-of-need programs use formulae based on bed-need and/or dollar amounts expressed as a percentage of operating costs. The validity of using bed-needs as a touch stone for hospital expansion has been roughly criticised. In the early 1960's, it was postulated that under a system of widespread prepayment, beds built would be used, (Roemer; 1961) and that medical providers create demand when the facilities are available. Others argued that the governmental bodies which regulate the health care industry will be primarily concerned with the well-being of the regulated industry rather than the public. It is also proposed that CON controls actually provoke increased hospital

construction by forcing applicants to accelerate their construction and expansion plans in order to get to the approving agency first (Havighurst, 1974).

Although CON programs do seem to have had a restrictive effect on investment in new beds, this decrease appears to have stimulated investment in the modernization of present resources, special equipment and facilities. During 1968-1972, the same time period when the growth of beds slowed by 5.4 percent, hosptials experienced a net increase in assets per bed of 20 percent. (Salkever, & Bice, 1979). Thus, it appears that CON programs, as cost-containment tools, are not totally effective. Savings in some areas are more than matched by increased expenditures in others. CON laws, by themselves, do not accomplish the goal which convinced the states to adopt the programs. Nevertheless, the basic philosophy behind the CON program is appealing--the appropriate allocation of health resources. Rather than abandoning the program improvement, such as CON review of all new health services in addition to capital expenditures mandated in recent federal legislation, strengthening of the CON monitoring process, and strict application of sanctions can significantly effect the success of the program.

The singular focus on CON as specified by federal legislation has discouraged other aspects of health planning such as decertification and swing bed techniques, coordinated health plans, manpower planning which is addressed in a later section, regionalized or shared services and innovative organizational arrangements among facilities. Many of these planning functions can be implemented in conjunction with the CON mechanism or the state licensure process.

Federal legislation is currently pending which would allow states to "swing" beds for individuals in acute hospital beds who are in need only of nursing home care. This policy would permit a hospital to "swing" a number of its beds from acute to nursing home beds and back to acute. Reimbursement rates for the swing bed when it provided long-term care could either be set at a rate not to exceed the maximum rate permitted in free standing nursing homes, a percentage of the acute care cost or a rate resulting from a more narrowly defined set of allowable costs.

Alternatively, states may permanently reduce the supply of hospital beds by decertifying beds where excess capacity is clearly demonstrated. For example, a state may use its licensure authority to prevent the provision of acute level care for certain unnecessary beds. In turn, the state may choose to recertify those beds for long term care use. Similar objectives may be accomplished through the sanctions available within the CON program (i.e., denial of CON to facilities who do not comply with bed reduction requests).

The NGA survey requested information not only on CON laws and the sanctions used to enforce the law, but also on whether the states have adopted, actually or in demonstration form, any other measures designed to control costs through health planning. The survey specifically requested information on swing beds, application of a state CAP on capital expenditures, state purchase of facilities, shared or regionalized services among facilities, mergers of public helath care organizations with private organizations, and formation of multiple organizational

units. The thesis behind this portion of the survey is that the focus on CON programs, to the exclusion of other health planning techniques, coupled with a virtual absence of any enforced sanctions within CON laws, has resulted in spotty and ineffective application of health planning. It is anticipated that the survey results will indicate that of the available tools, states are just beginning to take advantage of them.

Of the forty-six states responding to this survey section, 42 had either implemented or proposed a monitoring mechanism for compliance with CON decisions. Only 10 states reported instances where noncompliance was actually detected during FY 1978 and FY 1979. These states detected a total of 50 instances. Most states have several sanctions available. Six states could seek a jail sentence, 23 a fine, 26 suspension or revocation of license, 20 denial of reimbursement, and 24 denial of licensure. Injunctive Relief was also very common among the states. However, only 7 states sought action on these sanctions in 35 instances.

In other areas of health planning, 3 states reported a decertification program. The two health planning areas where the greatest number of states had implemented were "swing bed" (9 states) and Regionalized/Shared Services (9 states) Several states have also begun to consolidate their health planning processes or plans with categorical program planning. (11 states). Only one state had placed a cap on statewide expenditures, two developed programs for the closure and/or conversion of facilities, one mergers of public and private facilities, one supported the mergers of private facilities and three supported the formation of other multiple organizational units.

## CONSUMER INFORMATION

Consumers are not well-informed about medical technology treatment efficacy or consequences of occupation or lifestyle. Furthermore, neither consumers nor providers are well informed about prices, primarily because third-party payments and financing arrangements obscure or hide this information from the market. This fundamental lack of information creates the peculiar economics of health care that prevent competition and encourage inflation. This section focuses on state policies which restrict or encourage the provision of price information to consumers.

The American Medical Association and many state medical societies limit the ways in which physicians may advertise. Since promulgation of its Principles of Medical Ethics in 1847, doctors have been restricted in the ways in which they may advertise (limited to discreet listings of name, place, speciality and office hours), and have been prohibited from soliciting patients. While the AMA changed its principles in 1976 to permit limited advertising, state medical societies, state laws, or Boards of Medical Examiners that adopted the AMA's proscriptions on advertising and solicitation, have been slow to change. As a consequence, consumers have been effectively prevented from obtaining information about and access to less expensive medical care.

The federal courts and the Federal Trade Commission are slowly beginning to strike down and/or modify restrictions on advertising under the anti-trust laws. The medical societies' ethical standards restricting advertisement have been found to interfere with competition and injure the public in violation of the anti-trust statutes. To a large degree, physician' decisions control the costs of medical care by the prices which they charge, the medicine prescribed and the length of treatment. When consumers are prevented from choosing, because of lack of information, it becomes impossible to control the cost of health care through competition.

States can, and a few do, improve access to health information. Hospitals can be required to provide information on their finances to the general public. States may require that a patient be provided with a breakdown of hospital fees according to physician services, hospital room charges, laboratory fees, non-physician and ancillary care costs. Throught its state pharmacy board, a state can compile and publish lists of the most commonly used drugs and their prices, and require that this list be posted in drug stores. State freedom of information legislation may be applied to provide the public with access to financial information on state-run facilities, and certain kinds of health care organizations, such as HMOs, can be required to make available to the public information on their financial operations.

The NGA survey requests information on state laws and regulations which restrict advertising for doctors fees, hospital room rates, drugs, dental care and other services. It also solicits data on any laws which place an affirmative duty on individuals, employees or facilities to provide information to the public in these same areas. Forty-one states responded to this section.

Twenty-two states have at least one requirement that health provider fees/qualifications be made available to the public. Thirteen states had requirements on drug pricing information; 15 on HMO plans, 9 on hospital charges, 2 on physician fees, one on nonphysician practitioner fees, and four on ancillary service costs. Nine states require public information on physician qualificiations and seven on nonphysician qualifications.

Twenty-four states have at least one law restricting advertisements. The most frequent restrictions reported were for the advertisement of dental fees, (19), certain drug information (15), and physician fees (13). In addition, ten states have special restrictions pertaining to psychiatrists and seven states restrict the advertising of nonphysician practitioners.

## MANPOWER

The problems of health facility costs, excess capacity and maldistribution are paralleled in the area of medical manpower. The aggregate supply of physicians in 1970 was estimated at 323,000 and projections of future trends suggests that by 1990, the aggregate supply of physicians will approximate 594,000; more than 243 physicians per 100,000 population by most standards is an over supply or at the very least adequate. Nevertheless, there is serious maldistribution of doctors both in geographic terms and by specialty area. States in the South, North, Central and Mountainous regions have particular physician shortage problems. Even states in the Northeast, Pacific and Mid-Atlantic Region, whose overall physician to population ratio is quite high, show large intra-state variations between inner city, rural and urban areas.

From the perspective of health care cost containment, the number of physicians in specialty and subspecialty areas is alarming. Specialists tend to increase health care costs, due to the additional expense of the specialized education, insufficient demand for specialized services, higher fees for these services, and a higher rate of hospitalization of patients as compared with primary care physicians. Those cost increases are justified only to the extent that health care needs and quality of care correlate with specialty areas. A recent estimate of patient care requirements, however, suggests that perhaps 90 percent could be treated by primary care givers. (Scheffler, et al., 1978).

Increasingly, the states are seeking methods to insure an adequate supply and distribution of lower cost primary care resources including physicians, physicians assistants and nurse practitioners. The states have three tools for addressing manpower development; education financing, licensing, and reimbursement practices. The latter issue is addressed in the NGA State Guide to Medicaid Cost Containment.

### Education Financing

State involvement in health education financing takes several forms:

1) Loan and scholarship programs for students;
2) Financial support of teaching institutions; and
3) Financial support of residency programs.

A substantial portion of these funds can and should be tied to specific manpower development needs in the state.

Incentives to medical students or students in allied health professions to return to the state, practice in rural areas or in state public health programs may be incorporated into loan programs. In this instance, students receive funds for some or all of medical education costs. That loan is forgiven if the student returns to perform certain services in

the state. One problem experienced in loan programs with payback requirements and loan forgiveness is the optional "buy out" provision once education is completed. If the cost of "buying out" is not substantial, many students will choose that option. The states have played a substantial role in medical financing. In 1977, state funding for public medical schools comprised 90 percent of total education and general purpose programs (Hadley and Levinson, 1980). A portion of these funds and those provided to support residency programs can be targeted by the state on primary care residencies. In a similar fashion, the states can encourage allied health manpower development.

The section on manpower education in the Health Care Cost Containment Survey attempts to determine state efforts in financing medical education (medical schools, teaching hospitals, and other affiliated institutions) and in satisfying medical care needs in underserved areas. The questions ask whether or not states have state health service corps. or forgiveness loans, how much financial support goes directly to students and to schools and institutions. Asked also were questions about regulatory mechanisms concerning types of health service and loan programs and penalties associated with leaving these programs. The survey has been designed to develop a comprehensive picture of a state's commitment to financing medical education and servicing health care needs throughout the state. Forty states responded to this section of the survey.

Seven states have adopted and four additional states have proposed a mechanism to coordinate state health service needs as identified in the state plan with decisions on financial assistance to medical school, students and residency programs. Seven states currently regulate the type and/or number of residency programs.

Four states have developed a State Health Service Corps. In one state, a corps is proposed. Twenty states have adopted loan programs with service payback requirements and one additional state proposes such a program.

## Licensing

Licensing and certification in the health field originally was designed to assure quality of care. It has become an effective tool for encouraging a discouraging the development of new professions. The decision to license, register, certify, or in some other fashionenable the physician assistant or nurse practitioner, to practice is entirely a state decision; this decision should be based on the state's need to improve access to primary care and the potential cost-effectiveness of the practitioner. In addition to the licensing decision, the state must also determine the conditions of practice, educational requirements, regulations concerning administration dispensing and prescription drugs, etc. An adequate level of education and appropriate examination are necessary to assure the capability of those providing primary care. However, once the educational requirements become excessive and inflexible, and the examination becomes overly extensive, the basic purpose of having adequately trained, cost efficient health care delivery in underserved areas is defeated.

The agency responsible for regulating practitioners is an important factor in determining how active these professionals will be. Regulations by the State Board of Medical Examiners may be more restrictive than those issued by the Board of Physician Assistants or State Board of Nursing in certain areas. Restrictive regulations could take the form of limiting the authority and functions of PA's and NP's.

Physician supervision is another topic of controversy. Three types of supervision and control by physicians assumed in the States are: 1) direct "over-the-shoulder supervision; 2) physician's presence on the premises; and, 3) supervision by electronic means (phone). The more supervision required, the more limited a PA or NP would be in providing medical care.

Drug dispensing and prescription regulations also can limit the service of PA's and NP's. Many states do not allow PA's or NP's to prescribe or even dispense drugs. Others require a physician's signature with that of the PA's. In some states not even physicians may dispense drugs--only a pharmicist. Again, in rural or inner city areas, a doctor will probably not be close at hand and the effectiveness of a PA or NP will thereby be lessened.

The NGA survey asked for state policy on each of these issues as they pertain to four categories of allied health professions. Forty-six states responded to this section. In the majority of states without license FNPs, the State Board of Nursing was the regulating agency. The State Board of Medical Examiners is the regulating agency for the majority of states which license PA's. For both PAs and family nurse practioners the most frequently chosen physician supervision requirements were supervision by written protocol telecommunications. Similarly, for both PAs and FNPs the most frequent response to drug handling and prescription requirements was the provision of some administering, dispensing and administering authority.

## LICENSURE AND CERTIFICATION OF FACILITIES

The states participates in four of a five stage licensure, certification and accreditation process from the conception to the completion of a health care facility. In the first stage, the new facility must obtain an approved CON through the state's planning process. After construction, it must then apply to the state for a license to operate. Pending the outcome of onsite inspection for compliance with the state licensing act, the facility it may obtain a license. If the facility intends to serve Medicare recipients, it must meet a series of federal Certification standards which are administered by the state under federal contract. After six months, the facility may apply for accreditation by the Joint Commission on the Accreditation of hospitals, which inspects for compliance with a potentially different set of regulations. Finally, the state may choose to do a validation survey, generally done on a random basis.

Claims of duplication in the system are well-founded. However, the states can and have adopted strategies to streamline the process. Among them are interchangeable licensure, accreditation, and certification standards, or other types of survey coordination. The states may also adopt simultaneous inspections which potentially have several benefits, including reductions in facility administrative time (preparing for inspection), and allowing surveyors to discuss and resolve differences.

The NGA survey requested information on state cost containment efforts in the licensure and certification process for nursing homes, hospitals and, where appropriate, rural health facilities. Of the 46 states responding to this section, 16 have adopted interchangeable standards for at least 1 category of facilities, 6 simultaneous inspection, 33 other types of coordination, 34 technical assistance programs to facilities, and 14 a phase-in of requirements. Forty states have mechanisms for the evaluation of building fire and life safety codes.

## ALTERNATIVES TO INSTITUTIONALIZATION

The current interest in alternatives to institutionalization for the elderly, mentally disabled and developmentally disabled, is motivated primarily by the concern that many individuals do not need the intense level of services available in those facilities. Moreover, institutionalization infringes on the overall qulaity of life and creates and exacerbates dependency, depression and social isolation of individuals in nursing homes and institutions.

With the exception of the mentally ill and retarded, the elderly have the highest probability of requiring long-term care due to the extent of functional impairment, chronic illness, and disability. One central problem is the scarcity of alternatives to institutionalization, a situation which forces many people to choose between no care and the nursing home. Further, even where alternatives exist, they do not necessarily reflect current views on the nature of human and health services. The importance of independent living has led to the recognition that the traditional health delivery system is inadequate to deal with the array of service needs of the elderly. In particular, the fragmentation between non-institutionalization health services and other social and support services has made and continues to make independent living difficult.

These services can be provided through various models of care which can be grouped into two categories. The first category is residential and includes: congregate housing; and adult foster homes. The second category of services are grouped under community health and social services and include: adult day care; home health care services; and homemaker/chore services.

Financing for non-institutional long term care is provided independently by states and in joint state/federal programs unders several titles of the Social Security Act, the Older Americans act and some demonstration and research projects. These programs, however, do not form a comprehensive long-term care system, particularly where home-based care is concerned. The lack of a systematic approach has resulted in a very fragmented delivery system for home health care services on the one hand and home support services on the other. Individuals in need of care must apply to numerous agencies obtain financing for services, as no one program provides the comprehensive and complementary mix of services.

Given certain reservations, several studies have demonstrated that home based care is less costly than institutional care. Indeed, cost data from one project revealed that on a per diem basis skilled nursing care at home costs $22.80 as opposed to $45 for the equivalent level of institutional care, while health related care at home cost $11.15 per diem compared to $27 in an institution (Comptroller General, 1979). Another study found that home health care cost is less expensive only up to the point at which patients are greatly impaired (Comptroller General, 1977). However, non-institutional care will not necessarily be less expensive than institutional care for a variety of reasons. One reason

is that the cost of maintaining a home, plus whatever public funds such as food stamps or SSI income the recipient receives, contributes to the overall expense. A lack of complementary services may also force recipients of home care to return to institutions for treatment. Finally, increased availability of home health services may stimulate increased demand from those not currently receiving such services, which will again increase the cost of home health services.

The survey on alternatives to institutional care requested state non-Medicaid expenditures for both joint state-federal and independent state programs in the provision of home health services, congregate living, day care, foster care, management, and transportation services for three client groups, mentally disabled, developmentally disabled, and the elderly. In addition, information on efforts to coordinate the service package from all funding sources was obtained. Finally, state financing commitments to board and care homes and small group homes was requested. State responses to this section revealed: 1) that the majority of states are experimenting with noninstitutional services with independent and joint program funds; and, 2) that state efforts were quite unique. The survey was itself a case in point concerning fragmentation in services. Many state officials were unable to complete major portions due to shared jurisdictions.

## PREVENTION

Health prevention efforts can take several forms; 1) primary prevention which averts entirely the causes of disease; 2) secondary prevention which through early screening and detection prevents further development of the illness; and 3) teriary prevention when illnesses are treated to prevent complications. Tremendous gains have been made towards reducing and erradicating infectious and communicable diseases, primarily through improvements insanitation, housing, nutrition and immunizations--primary prevention efforts. The health care cost containment consequences of these improvements are clear.

Today, the leading causes of death--heart disease, cancer, accidents, etc. are less amenable, to the strategies used previously. The changing nature of illness, and its significant relationship to lifestyle and environmental hazards have altered the necessary focus of primary prevention efforts. The state role in lifestyle change or willingness programs, and the large range cost containment implications are not yet clear.

The multiple of funding sources for prevention efforts at the state and federal level make it difficult to develop a comprehensive prevention strategy incorporating the traditional (i.e. communicable disease) and nontraditional (willingness programs).

The NGA survey section on Prevention asked states to provide information on prevention coordination efforts and the level of state effort in independent and joint federal/state prevention programs. Forty-two states responded to this section. Thirty-five of these states reported prevention coordination efforts. These mechanisms and the level of state effort are discussed in the abstracts.

## ABSTRACTS

In the following section, each state's major health care cost containment initiatives are briefly summarized. Information across the nine topic areas was not always available or is not included for all states. In some cases information reported in the survey was difficult to interpret and, therefore, is not included. In other instances, data were not available at the state level in the form requested or was not reported. Each abstract is organized in the same way, beginning with a description of efforts to coordinate health care cost containment efforts across state agencies and proceeding through the remaining cost control areas.

## ALABAMA

The State of Alabama's Insurance Commissioner is involved in several of the activities of Blue Cross/Blue Shield and other Commercial health insurance carriers. Insurance commissioner approval is required for benefit packages offered by Blue Cross/Blue Shield and other commercial carriers. Blue Cross/Blue Shield's premium rates and Medigap benefits also require approval. In regards to other commercial carriers Medigap benefit legislation is being drafted which will require minimum coverage standards and a 60 percent claims pay out for individual Medicare Supplement policies and 75 percent for group policies. This proposal will be introduced in the 1981 legislative session.

To aid in the development of appropriate health manpower, Alabama has implemented several policies including a loan program which gives medical students the option to repay either in cash or in service. Repayment in service requires the loan recipient to practice for 4 to 5 years in a medically needy community ranging from 5,000 to 10,000 inhabitants, practice in a public health role, or work in a state institution. A breach of contract by the recipient renders him or her immediately liable for the unpaid balance. Furthermore, failure to fulfill the agreement or pay the sums constitute reasonable grounds for the revocation of the physician's medical license. A total of 186 persons have or will enroll in the program from 1978 to 1981 (estimated), with an average of 21.5 persons buying out of the program each year. Of the total institutional assistance provided for residency programs, over 60 percent of the funds were specifically targeted for primary care residency programs from fiscal year 1978 to 1980.

While state financial assistance for training of non-physician personnel is limited to registered nursing programs, nurse midwives and physician assistants are certified for practice by the Board of Medicaid Examiners. Requirements for physician supervision of these allied health personnel include the physical presence of the physician as well as supervision by written protocols. Current regulations prohibit them from prescribing drugs. Between Fiscal Year 1978 and Fiscal Year 1980 it is estimated that 9 nurse midwives and 37 physician assistants will have certified to practice in the state. Another group of allied health personnel, family nurse practitioners, are not licensed by the state although they do practice in Alabama.

In terms of the licensing of health facilities, Alabama has adopted measures such as interchangeable state licensure, voluntary accreditation and certification of standards for hospitals. For both hospitals and nursing homes the state has adopted coordination between licensure, accreditation and certification surveys, a technical assistance program for licensure and a phasing-in of requirements. Adoption of these measures should contribute to the reduction of time and money spent on licensing and certification, as well as enable hospitals to better meet the requirement of the licensing board. The safety code evaluation mechanism for health care facilities also includes an examination for inconsistency with other state regulations, cost-benefit analyses, public hearings and an appeals process.

Health promotion and disease prevention activities in Alabama are coordinated by the Department of Health. In addition to joint state-federal programs in prenatal care, family planning, VD control, etc., the state funds independent

programs for perinatal care, TB screening and control and hypothyroid testing. For these latter programs, Alabama spent in excess of $1.75 million for Fiscal Year 1979.

In the area of alternative to institutional care for the elderly, the state of Alabama participates with the federal government to provide home health services, homemaker and other chore service, day care, and transportation. The state share of these programs approximated $1 million for Fiscal Years 1978-1980. The transportation program accounts for the bulk of expenditures totalling $750,000 in 1978 and $800,000 in 1979 and 1980. For the mentally disabled, joint state-federal programs (primarily Title XX), provide transitional homes, day care and social services. The state has also received a Community Support Project grant to devise a system for providing the full range of service to this client group through case management. Finally, the state provides independent support in the operation of Mental Health Center Group Homes and foster care. This support subsidized 4 homes and 60 foster care sites in 1979.

Alabama has also undertaken an applied research and demonstration project to examine the levels of services along the continuum between the institution and the community for their developmentally disabled population. The state independently supports an extensive program to provide congregate living and day care services. These same services and care management receive joint state and federal program support as well.

## ALASKA

The Governor's Budget Review Committee, through its budgeting process, coordinates statewide health care cost containment policy. The budget process is also used for coordinating state health and welfare programs. According to state statute, all third-party insurance carriers must, at a minimum, provide benefit coverage for newly born children. Premium rates charged by Blue Cross, Blue Shield and health maintenance organizations must be filed and approved by the insurance commissioner. For commercial carriers, Alaska law specifies the size (5-21) of the Board of Directors and limits the term of office for initial directors to one year from the date of incorporation but does not require premium rate approval. Alaska has no minimum benefit standards for health insurance policies marketed or supplements to Medicare. However, a proposal is under consideration which requires that an outline of coverage be provided to every potential insuree.

To enforce its Certificate of Need program, the Alaska Health Resources Development Unit oversees bed construction. The state may seek injunctive relief against individuals or facilities for bed construction or capital investment in excess of CON approved expenditures. It was not sought in FY 1978 or FY 1979. A proposal to require CON approval for "specific diagnostic or therapeutic equipment regardless of location" is currently pending. Alaska is currently considering proposals on a first come first served basis but proposes to group proposals in compliance with new federal requirements. Alaska's CON program does not contain a mechanism to decertify unneeded beds or facilities.

Alaska has no mechanism to coordinate state health manpower needs as identified by the state health plan, and does not regulate the type of physician residency programs or the number of individuals in those programs. While there is no State Health Service Corps, Alaska does have a Student Loan Program which has a forgiveness clause (up to 40 percent of the loan amount) for all students who return to the state after schooling. Because field of studies is not a determinant of loan eligibility it is not possible to determine the amount supporting medical students. Alaska is a member of the Western Interstate Commission for High Education (WICHE), a non-profit regional organization. The purpose of this organization is to help provide high-quality, cost-effective programs to meet the education and manpower requirements of the member states. "WICHE funds are sent to the school to be used to cover the difference between resident and non-resident tuition, thus allowing students to pay in-state rates." Alaska is also a member of WAMI Medical Education Program which is using decentralization to provide improved distribution of medical education and patient care personnel throughout the Pacific Northwest and Alaska.

Family Nurse Practitioners (FNP) receive financial assistance for education directly from the state provided they sign a 2-year contract. If the FNP leaves before the 2-years are up, repayment on a prorated basis is required.

Since 1978, Alaska has adopted several measures to contain costs in licensing and certification of facilities including:

1. establishment of a satellite office in Anchorage, thus reducing plane fare costs and staff overtime;

2. development of a Memorandum of Understanding with the Public Safety Administration to perform life safety code surveys by fire marshals stationed in Fairbanks, Anchorage and Juneau instead of all trvel out of Juneau, thus, plane fare and per diem costs are reduced;

3. combining surveys geographically; and

4. covering all programs in which a provider participates in one facility survey, thus reducing duplication for small hospitals most of which also provide ICF and SNF care.

The evaluation of building, fire, and life safety code requirements for health care facilities includes examination for duplication of other state codes or regulations, examination for inconsistency with other regulations, cost-benefit analysis, public hearings, appeals process for codes and regulations.

Alaska has two programs providing coordination for state efforts in health promotion and disease prevention including a Health Education Program working on public information and community organization. The other program is concerned with wellness and health promotion. Both are funded exclusively by the state receiving annually an average of $33,000 between FY 1978 and 1980.

# ARIZONA

While there is currently no formal mechanism for the coordination of statewide health care cost containment policy in the state of Arizona, the issue has been the focus of major initiatives developed by the Governor. During the last year, central issues included compliance with federal health planning law and the Governor's Indigent Health Care Initiative (Medical Cost Continment Program, 1979). The latter makes extensive use of capitation financing arrangements with HMOs and health evaluation and screening for elderly.

In 1972, Arizona adopted a rate review program for all health care institutions. That program was amended in 1973 to include uniform reporting and again in 1980 to limit review to acute hospitals and nursing care institutions. The current program is voluntary covering all major payors (Blue Cross, commercial carriers and private individuals, Arizona does not have a Medicaid program). A joint review by the state health department and planning agency examiners charges any facility expenditure according to facility characteristics. Administrative costs for the program were $143,000, $169,000 and $167,000 respectively for 1978, 1979 and 1980.

The state of Arizona presently does not regulate the activities of health insurance carriers. However, recent legislation will provide the insurance director the power to disapprove any disability policy if the benefits it provides are unreasonable in relation to the premium charged. The law applies only to commercial carriers and will have no effect on Blue Cross/Blue Shield and HMOs.

Arizona state law requires the publication of price information for health care institutions including how rates and charges relate to operating income and expenes of facilities. In addition price information by service must be posted conspicuously in the reception area of each health care institution. The state's generic drug law allows drug substitution (with physician concurrence as indicated on each prescription form) and, if the substitution is labelled clearly as to name and manufacturer. HMOs, referred to as Health Care Services Organizations in Arizona, are required to file materials for inspection and copying by the public. The state also has several laws which restrict advertising including that by physicians.

Restrictions in advertising occur in many areas such as dental care and psychiatric care fees. Advertising by physicians defined as "unprofessional conduct" is also prohibited. This has not been enforced and efforts to repeal this reference are still unsuccessful.

To develop the state's manpower resources, Arizona has adopted a loan program for medical students requiring payback in services. Service payback is year for year, with a minimum of two years service in a medically underserved area of the state. Student may buy out of the program by repaying the loan amount, 7% interest and a $5,000 penalty with one year. The program's capacity doubled during 1980 and is expected to increase by one-half again in 1981. In 1980, the state provided $1.4 million out of total residency support of $9.6 million for residency programs in community and family medicine and general practice.

Nurse midwives and nurse practitioners are registered by the state but not licensed. Physicians assistants are certified for practice by the National Commission on Certification of PAs. NMs and FNPs are usually examined by the Practitioners Association and by the state agency which also gives educational approval. The State Board of Nursing is the regulating agency for NMs and FNPs. The Joint Board of Medical and Osteopathic Examiners regulates PAs.

In limited cases, supervision of NM, FNP through telecommunication with doctors is adequate. However, supervision by written protocols and by a physician on the premises is required. Supervision of PAs by telecommunication and/or written protocol is adquate.

NMs and FNPs are prohibited from administering or prescribing drugs; they do have some dispensing authority if they are employed or on contract with the County Health Department in underserved areas. PAs have some authority to administer, dispense, and prescribe drugs. There have been dramatic increases in the number of FNPs and PAs practicing in Arizona between FY 1978 and FY 1980.

In steamlining its licensure and certification process Arizona has adopted coordinated standards for hospitals. Furthermore, surveys for licensure and certification of hospitals, SNFs and rural health facilities are coordinated to the maximum extent possible. Consulting staff provides technical assistance to nursing homes throughout this process. The state has also adopted a mechanism for code evaluation which includes a public hearing and an examination for inconsistency across state regulations.

Prevention efforts in the state have focused in recent years on joint federal and state funded immunization, Title V services, and venereal disease control. In addition, the state independently funds a TB screening and control program.

In FY 1980, the State Aging and Adult Administration received for the first time a state appropriation for Home-Care for aged and disabled adults. Of that appropriation approximately $149,800 is for home health services and $1,334,500 for homemaker and other chore services. In 1981, the state Division of Behavioral Health Services will implement a $732,000 initiative to establish a Community Mental Health Residential Treatment System.

## ARKANSAS

Health and welfare programs in Arkansas are coordinated through a bi-monthly meeting of representative from the Governor's office, the Department of Health and Department of Human Services.

While Arkansas does not have or anticipate a provider rate-setting or budget review program, the state insurance law requires approval for benefit package premium rates (including loss ratio), medigap benefits and cancer insurance of all third party carriers. Approval is required for all types of policies offered by Blue Cross/Blue Shield and health maintenance organizations, whereas for other commercial carriers approval applies only to individual policies, group policies are exempted.

To enforce its Certificate of Need program Arkansas has an agreement between the Health Planning Agencies (SHPDA and the HSAs) and the Medicare Provider Audit Division and state institutional licensing agencies. In FY 1978 and FY 1979, this mechanism detected 5 instances of noncompliance. Currently, the state may suspend, revoke, deny licensure, withhold reimbursement or grants and/or enjoin violators of CON law. In addition, the state has proposed but not yet implemented a system of fines for violators. The CON program now covers in addition to inpatient hospitl services, outpatient hospital services and all clinic services in public facilities. While the state now groups CON applications for similar services that are submitted in the same review cycle, a proposal is under consideration to group every six months. In other areas of health planning, Arkansas has several active demonstration programs in shared or regionalized services among facilities and in consolidating the health planning process including the plans themselves across several categorical program areas.

Restrictions on advertising for hospital room charges, physician's and dental care fees, etc. are considered unenforceable and unconstitutional in Arkansas.

State health service needs as identified by the state health plan are coordinated with financial decisions on medical students, schools and residency programs at teaching hospitals by the Governor's Health Manpower Planning Committee. The state has also developed a loan program to finance the education of medical students requiring a payback in service for a limited period of time. Between 1978 and 1981, approximately 60 students will have enrolled in the program annually, with total financial assistance averaging $295,000 annually. Upon completion of the medical education the enrollee is required to practice in a qualifying community for a minimum of two continuous years. For each year of practice, one year of assistance is converted to scholarship. The penalty for leaving the program is repayment of the loan with 10 percent interest per annum which accrues from the date each payment was received by the recipient. The majority of the funds allocated to residency programs are specifically targeted for primary care residency programs, including community and family medicine and general practice. From FY 1978 to FY 1980, approximately 58 percent of the residency programs were so targeted.

State only funds in Arkansas for health promotion and disease prevention have been allocated to the senior meals on wheels and senior congregate services. Arkansas's In-Home Services Program for the elderly population

provides a mechanism for the coordination and delivery of noninstitutional health and support services. The In-Home Services Program is administered by the Office on Aging of the Department of Human Services and is implemented statewide by the eight Area Agencies on Aging (AAA's). The program is funded by a state revenue allocation (excluding $2 million), an Administration on Aging Grant, and a contract with the Division of Social Services for Medicaid reimbursement of Personal Care costs. Two employment programs, CETA II-D and the Department of Labor's Title V, provide funds to the Area Agencies to employ the economically disadvantaged and older workers. Thus, while one segment of the elderly Arkansas population is being served another is being employed.

Each Area Agency on Aging employs an In-Home Services Supervisor and specially trained Caseworkers to coordinate services within the aging network. The In-Home Services Supervisor receives referrals from various sources such as physicians, the Division of Social Services, potential clients, and other providers of aging programs. These referrals are assigned to a Caseworker who assists in determining the needs of the elderly using person as standardized assessment instrument and works with such clients to assure that these needs are met.

## CALIFORNIA

The state Certificate of Need program monitors bed construction and capital investment compliance with approved CON expenditures. Sanctions available for violation of CON approved expenditures are suspension of license, revocation of license or a fine. The latter sanction was used once during Fiscal Year 1978. Outpatient hospital services and clinic services are also covered in the CON program. While the state's CON program does not contain a mechanism to decertify unneeded beds or facilities, delicensure of some beds is a condition of certain exemption applications. California has also adopted a swing bed policy on a demonstration basis.

Coordination of licensing, accreditation, and certification surveys also have been adopted for hospitals, nursing homes and rural health clinics. A technical assistance program for licensure and the phasing-in of requirements have been adopted for these three types of health care facilities. For hospitals, simultaneous inspection by state surveyors and the Joint Commission for the Accreditation of Hospitals has been adopted. California's evaluation mechanism for building, fire and life safety codes contains several measures such as examination for duplication of and inconsistency with other state codes or regulations, cost-benefit analyses, a public hearing and an appeals process for codes and regulations.

Information on the cost of drugs is required by regulation to be made public. The state also has restrictions on deceptive advertising for hospital room charges, physician, dental care and psychiatric care fees, non-physician practitioner fees, drugs and ancillary services costs.

Blue Shield and health maintenance organizations are regulated by the Health Plan Units of the California Department of Corporations. Benefit packages offered by Blue Cross and commercial carriers must be approved by the California Department of Insurance. Minimum levels of benefits have been established for individual health insurance policies. All premium rates offered by Blue Cross and individual health insurance policies offered by other carriers are required to be filed with the Department of Insurance, although the Department has no authority to disapprove the rates. Premium rates for group policies are not required to be filed. Individual Medicare supplement and individual cancer insurance policies offered by commercial carriers are required to meet minimum benefit levels established by the insurance department. Members of the board of directors of commercial insurers must abide by certain requirements of the California insurance code, while the board of directors of Blue Cross may not be comprised of more than 50 percent physicians or representatives of member hospitals.

The coordination of state health service needs, as identified by the state health plan, with plans for financial assistance to medical students, medical school programs and hospital residency programs, is under discussion in California, and several proposals for residency programs already exist. The University of California is required, through the budget process, to rationalize its development of residencies in terms of several elements of state manpower policy. The University is also required to begin reducing non-primary care residencies. Financial assistance for residency programs came to approximately 33 percent of the total allocated for medical student programs, or $33 million annually from Fiscal Year 1978 to 1980. Of this amount,

primary care residency programs received $1.4 million, $1.6 million and $1.5 million for each fiscal year. The state also provided over $800,000 in financial assistance, which did not require a payback in services, directly to medical students in Fiscal Years 1978 and 1979. Prior to 1978, a loan program with service payback functioned where loans to recipients were forgiven if the student worked in a medically underserved area upon completion of the medical education. That program still exists in statute and is now being evaluated.

A broad array of allied health personnel are licensed to practice in California. They include nurse midwives, family nurse practitioners, nurse psychotherapists and physician assistants. These groups are supervised by telecommunication and written protocols. While physician assistants can administer drugs but not prescribe, nurse midwives, nurse practitioners and nurse psychotherapists can prescribe, dispense and administer. To date, 169 nurse midwives have been certified in California and 619 physician assistants have been licensed.

California's Department of Health has received funds from the Center for Disease Control to develop an innovative program in Health Education/Risk Reduction, as well as additional funds for four county-level intervention programs. The program has several components including a statewide inventory of health education/risk reduction efforts, assistance to those communities that would like to develop a community-wide approach to the reduction of health risks, development of research methodologies to identify the existence of risk factors in communities and target populations, and identification of information sources on morbidity and mortality stemming from chronic diseases and the existence of the associated risk factors. The program also seeks to develop, implement and evaluate strategies of health education aimed at modifying personal behavior so as to reduce the risk of chronic disease.

California has allocated a relatively large amount of state funds to joint state-federal and independent state preventive health programs. Joint prenatal, postnatal and perinatal care programs received $6 million, $17 million and $18 million in Fiscal Years 1978, 1979 and 1980 respectively. An additional $643,094, $10 million and $11 million were further allocated to independent state programs. Venereal disease, teenage pregnancy and communicable disease control also received relatively substantial sums of money. Nutrition education for children and pregnant women received over $24 million in each fiscal year. Joint state-federal programs in immunization and early and periodic screening and diagnostic testing received an annual average of $2.6 million and $12.5, respectively, million in each fiscal year. Independent state programs received respectively an additional average of $1.4 million and $7.1 million annually. Preventive health projects for children and youth received over $4 million each year. Efforts in health promotion and disease prevention also focused on hypertension screening and stress management, PKU and TB testing and control, and cervical cancer detection. For a sample of prevention programs where data are available, California's estimated contribution to joint state-federal prevention programs is $74 million and for independent state programs $29 million.

California provides in-home service to the elderly through a variety of sources. However, no breakdown was available. The state, through the Multipurpose Senior Services Demonstration Project will systematically address the issue of designing the most effective delivery model for coordinating services to the elderly. Eight sites have been selected for participation. The project is requesting waivers from Medi-Cal to permit funding of services from home

management to prevention under this program. The project has an on-line information system which will assist in case management and subsequent evaluation.

California has also developed a model for Mental Health programs which is to be implemented on a pilot basis in three counties. The aim of the proposal is to ensure equitable funding for counties, to reduce hospitl utilization and to provide a comprehensive, uniform range of mental health services. The system will be locally administered. The model recommends minimum service standards (i.e., 24 hour active intensive care, supervised out of home placements, etc.) tied to a minimum level of service per 100,000 population.

## COLORADO

A hospital rate-setting and budget review program was adopted by the Colorado Assembly in October 1977 and placed under the auspices of the Colorado Hospital Commission. The Commission was later disbanded by the assembly in March 1980. From the data provided, the Commission held total expenditures for short stay hospitals to an increase of 8.62 percent from FY 1978 to FY 1979, and 7.89 percent from FY 1979 to FY 1980, far below the rate of inflation nationwide. Since data on FY 1981 expenditures are not available the impact of disbanding the commission on expenditures is unknown.

In terms of health insurance, both public and private insurance carriers must obtain the commissioner's approval for activities such as benefit packages, premium rates, medigap benefits and cancer insurance. Furthermore, the loss ratio on medigap benefits is required to be not less than that established by the commissioner. Currently, the ratio has been set at 60 percent in Colorado which means that for every $1 of medigap premium the insurnce carrier must return in the aggregate 60 cents in benefits. Insurers issuing medicare supplemental policies in Colorado are required to submit the previous year's loss ratio, as well as other documents and data the insurance commissioner may require. If, in the course of the proceedings, a determination is made that the insurance carrier's loss ratio of the previous year was less than the ratio prescribed by the state, the commissioner may authorize a reduction on the premium rates of medicare supplemental policies so as to achieve the specified loss ratio.

The health planning process in Colorado includes a Certificate of Need program which monitors bed construction and capital expenditures. Applications for bed construction or capital expenditures which are approved are required to file reports on the proposal on a quarterly basis for the duration of the Certification, approximately one year. Noncompliance with or violation of the CON are punishable by legal and/or administrative sanction such as an injunction, a fine or imprisonment, and denial of licensure or reimbursement. During FY 1978 and FY 1979 no instances of noncompliance were detected and consequently no sanctions imposed. Other areas covered in the CON program include outpatient hospital services, physician office services and specific diagnostic or therapeutic regardless of location. Applicants to establish new health care facilities or capital expenditures are now considered on a first come first served basis, although the CON program is planning to group all similar proposals.

Consumer information regulations in Colorado require individuals, facilities or employees to make public information on drug costs. When a drug is avertised by the common brand or proprietary name, the generic name is required to be included in the advertisement. At the same time advertising on physician's fees, psychiatric care fees and drugs are restricted.

Concern over family oriented general practice has prompted the state to provide incentives for residencies in family medicine. Financial assistance for community and family medicine and general practice residency programs were 4.9 percent, 5.7 percent and 4.2 percent of the total financial assistance for programs for FY 1978, FY 1979 and FY 1980 respectively. Funds were provided to medical students which did not require a payback provisions. Financial

assistance was also provided directly to registered nurses as well as colleges, universities and affiliated hospitals for the education of registered nurses. One group of allied health personnel, family nurse practitioners, are licensed in the state but as registered nurses.

Licensing and certification of health care facilities are done by the same agency, but there is no coordination of any kind with accreditation. There is also an evaluation mechanism for building, fire and life safety code in health care facilities. This evaluation also includes examination for inconsistency with other state regulations.

The Department of Health has established a Health Promotion Consortium to coordinate statewide efforts in health promotion and disease prevention. State funds have been spent for joint state-federal programs such as prenatal and postnatal care, control of venereal disease, nutrition education, screening, and control of TB, control of communicable disease and other health projects for children and youth. Between $5 million and $6 million were allocated by the state to joint state-federal programs. State only programs such as cervical cancer detection, control and screening of tuberculosis and the control of communicable disease received an annual average of $1.4 million from FY 1978 to FY 1980.

## CONNECTICUT

Connecticut health care cost containment policy is coordinated across health and health-related programs by the Governor's liaison person. The Office of Policy and Management coordinates state health and welfare programs.

Some of the activities of health insurance carriers do require the approval of Connecticut's insurance commissioner. For Blue Cross/Blue Shield and health maintenance organizations the commissioner's approval is required for benefit packages, medigap benefits and premium rates. Premium rates offered by other commercial carriers require approval on individual policies only. The sale of cancer insurance in Connecticut is prohibited by general statute.

To maintain compliance with CON approved bed construction and capital investment expenditures, compliance conditions are made part of the approval granted by the Commission on Hospitals and Health Care. Three instances of noncompliance in Fiscal Year 1978 and seven instances in FY 1979 were detected by the monitoring mechanism. Injunction is the sanction available when violations occur. The state Certificate of Need program also covers outpatient hospital services and clinic services. Applications to the CON program for new health care facilities or capital expenditures are currently considered on a first come first served basis, but the program is planning to group such proposals in the future. The state has adopted on a demonstration basis a swing beds program and has consolidated the HSA health planning process and planning activities for other categorical health programs into a single process. The state legislature has adopted a program to encourage shared or regionalized services among facilities.

The licensing and certification procedure in Connecticut attempts to reduce administrative time and costs spent on these activities by interchanging state licensure, voluntary accreditation and certification standards for hospitals. Furthermore, hospitals and long-term care facilities may in the future be granted "deemed status" for state licensure at the option of the Office of Public Health. Deemed status is a procedure whereby the annual state licensing survey is forgone if the hospital or long-term care facility has not had a change in ownership or administration, or if violations have not been found. Simultaneous inspection by the state surveyors and the Joint Commission for the Accreditation of Hospitals is also anticipated for late 1980 or 1981. Other instances of coordination between licensure, accreditation and certification occur between ESRD and NIMH for psychiatric facilities. Connecticut also has technical assistance programs for licensure.

In the area of public health, the Chronic Disease section of the Department of Public Health is focusing on primary prevention of chronic diseases in its attempts to reduce cardiovascular illnesses and death. The Chronic Disease section offers three programs in its preventive health campaign: identification and control of high blood pressure; smoking cessation; and, preventive health services worksite initiative. In addition to these programs, health dietary habits and physical fitness are also promoted. State expenditures for joint state-federal programs, such as hypertension screening and coordination, approximated $21,000 for Fiscal Years 1978 through 1980, $20,000 and $31,000 in FY 1978 and FY 1980 for smoking cessation, and approximately $600,000 a year from FY 1978 to FY 1980 for nutrition education. Funds are also being spent on

occupational alcoholism intervention with an annual average of $45,584 for joint state-federal programs and $121,726 for state programs. Prenatal, postnatal, and perinatal care and teenage pregnancy receive funds as well as hypothyroid testing. Health projects for children and youth receive over $500,000 per year, while the program for early and periodic screening and diagnostic testing received a similar amount, over the 1978 to 1980 period.

Nurse midwives are allowed to practice in Connecticut under the physical supervision of a physician. The state also operates a tuition waiver program at the University of Connecticut School of Medicine.

The State of Connecticut has implemented and/or supported several innovative programs for the elderly including SAIL--Strengthened Assistance for Independent Living and TRIAGE a joint federal-state research program. The SAIL program provides coordination, assessment and monitoring of service delivery to the state's elderly ($1 million for case management alone in 1980). Indpendent state efforts in home health were $371,000 in 1980, $150,000 for day care, and a $10.2 million foster care effort. The Connecticut General Assembly has allocated money to develop four new model congregate living housing facilities for the state's elderly population. Beginning in 1981, $50,000 has also been appropriated for rent subsidies in private congregate facilities. Most initiatives in the human services area are tied to Title XX, but the state substantially overmatches. In 1978, Connecticut began developing a model Adult Day Care Program. On the basis of an evaluation of that program, four new day care positions per 1000 elderly persons were recommended. Addition of Adult Day Care to the Title XIX plan was also proposed.

State only program funds for the mentally disabled concentrated on home health ($156,332 in 1980), homemaker services ($43,291), day care ($3.9 million) and case management ($31,456). The state also provides extensive state non-medicine dollars for the support of the Community Mental Health Center program ($11.8 million) and support to day treatment hospitals ($298,033). Connecticut participates in the HUD/HEW Demonstration Program for the mentally disabled through the development of small scattered site housing. The state subsidizes 3 supervised apartments and 10 small group homes for this client population.

Connecticut's DD Program funds are used only for innovative programs designed to increase the availability of services to prevent institutionalization. Most programs funded by DD grants continue as self-sustaining programs after DD funds expire. Since 1978, the DD Council started a statewide private, nonprofit agency to serve persons with autism. That agency is thriving and has been successful in establishing a mandate for service planning in state statutes.

## DELAWARE

Delaware's health care cost containment policy is coordinated by the Chief of the Bureau of Health Planning Resources Development within the Department of Health and Social Services.

Health insurance premium rates offered by insurance carriers are subject to the approval of Delaware's insurance commissioner. Policy approval authority exists for medigap benefits and cancer insurance; however, no authority exists to prescribe benefits offered.

Delaware has no laws which require individual facilities or providers to make information available to the public. In addition, only one state law limits advertising--advertising fees charged for dental care is prohibited by statute where the nature of the work must be variable.

In light of proposed federal regulations, Delaware is contemplating a mechanism to monitor bed construction and capital expenditures that have been approved by the Certificate of Need program. Violation of CON approved expenditures or expenditures undertaken without CON approval are subject to legal and administrative sanctions including a fine, revocation of license, denial of reimbursement, denial of licensure, restriction of license or court restraint. During 1979, none of these sanctions were imposed. The state CON program also covers outpatient hospital services and clinic services. Applications for new health care facilities or capital expenditures are grouped together and the best application selected. Other measures which exist in Delaware include swing beds, shared or regionalized services among facilities and consolidation of HSA health planning process with planning activities for other categorical health programs into a single process. These measures are not the result of legislation or demonstration authority; they exist as a result of the initiative of the parties involved and/or the encouragement of the health planning agencies. Given the current ratio of short-term acute general hospital beds to population in Delaware (3.43 per thousand), bed decertification is not anticipated.

Physician and nurse practice acts in Delaware do not permit physicians assistants and nurse practitioners. The latter group, however, may be licensed as RNs.

Delaware has adopted interchangeable licensure and certification standards for nursing homes and is currently considering a proposal to do so for hospitals.

Delaware, unlike most states, does not have county or municipal public health institutions. The county health units are State Agencies; therefore almost all of the public health promotion and prevention programs are administered by this Department. The Division of Planning, Research and Evaluation, the policy planning and research arm of the Department, has the primary role for the coordination of the various programs. The State Health Planning and Development Agency (SHPDA) is organizationally in this Division and it has the responsibility of reviewing all federal grant applications for Health Programs and submitting their findings and recommendations. In addition to considering the relationship to other programs, the goals and objectives in the State Health Plan (Health Plan for Delaware) provides the basic criteria for these grant

application reviews. The Plan, therefore, serves as an effective tool for coordination. The Department's Division of Public Health has the primary responsibility for conducting various health promotion and disease prevention programs.

In the area of health promotion and disease prevention, Delaware has allocated an annual average of $271,020 to joint state-federal programs on senior congregate services and to independent state programs an average of $1.2 million in each Fiscal Year 1978, 1979 and 1980. Other joint programs which received and are receiving funds are prenatal and postnatal care, venereal disease control, cervical cancer detection, nutrition education for the elderly, immunization and early and periodic screening and diagnostic testing. Delaware also funds an independent state program on cervical cancer detection. control, cervical cancer detection, nutrition education for the elderly, immunization and early and periodic screening and diagnostic testing. Delaware also funds an independent state program on cervical cancer detection.

To promote non-institutional living for the mentally disabled, Delaware implemented a Community Release Service designed to maintain the chronic individual in the community. This service utilizes group work techniques and non-institutional activities including trial stays at a halfway house before placement in a small group home. People Places II, Inc. received state funds for group home services ($121,400 in FY 1980).

# FLORIDA

Florida's Office of Planning and Budgeting, Human Resources Policy Unit is responsible for coordinating health care cost containment and for broad human resources planning, budgeting, and policy. The Department of Health and Rehabilitative Services is responsible for coordinating state health and welfare programs. It is a consolidated health, welfare and social service agency with decentralized operations through 11 Districts and statewide co-location of service at the local level.

Florida's enabling legislation for its Hospital Cost Containment Board became effective July 1, 1979. That Board, located within the Department of Insurance has a mandatory uniform reporting system designed and ready for implementation but has not yet received the first hospital report. The Board will review revenues and expenditures according to hospital peer groupings. High cost hospitals, those which exceed the 80th percentile on cost per admission or revenues per admission, will be analyzed. Assessments against hospitals will be used to fund the Board. The Board is composed of nine members; three major health care purchasers, three consumers, one of whom represents the elderly, and three providers. The Board is explicitly instructed to use planning resources.

Florida also currently requires approval by the insurance commissioner of benefit packages, premium rates, medigap benefits and cancer insurance for Blue Cross/Blue Shield and other commercial carriers. Benefit packages and premium rates of Health Maintenance Organization require approval by the insurance commissioner as well.

Florida has passed recent legislation expanding CON review authority and revising submission procedures. This bill included a CON monitoring authority. In 1979, only 1 instance of non-compliance with CON was detected and the sanction used was an injunction. Outpatient hospital services are covered in Florida's CON program. Coverage of specific diagnostic or therapeutic equipment with some limitations was included in the recent legislation discussed earlier.

Florida statute includes several provisions requiring the provision of certain information to the public and restricting the advertising of other information. State law requires the provision of cancer research findings or therapeutic and preventive potential. Statute also requires the submission by hospitals and nursing homes of itemized bills in "ordinary laymen's" language of all charges incurred by a patient. Advertising by physicians is regulated but fee advertising is not prohibited. Advertising is also permissible, but restricted in the areas of hospital room charges, drugs and ancillary services costs. Fraudulent or misleading advertising is strictly prohibited.

Florida has no mechanism to coordinate health service needs and does not regulate physician residency programs. There is no State Health Service Corps or loan programs with payback provisions. Florida has been giving increasing amounts of financial assistance for medical school and residency programs but does not target these funds to specific programs. The funds are given in lump sum to affiliated hospitals for all services. Financial assistance is not provided directly to students.

Florida has all four types of allied health personnel. Nurse midwives are certified by the Board of Nursing and are registered with the Public Health

Agency. Physician assistants (PAs) are certified by the Board of Medical Examiners. All must have educational approval by a state agency. The different categories of allied nursing personnel are regulated by the State Board of Nursing while PAs are regulated by the State Board of Medical Examiners. Nurse midwives are also regulated by the Department of Health Rehabilitative Services. Selected functions of nursing personnel require supervision by telecommunication; written protocols are adequate for all other functions. Nursing personnel have some drug dispensing authority. Drug prescribing authority is now being considered. As of April 1980, Florida had 77 nurse midwives, 106 nurse practitioners, and 3 nurse psychotherapists.

The Health Education Unit of Florida's Health Program Office has a federally funded Health Education-Risk Reduction Program. The major goal of this program is to expand the scope of the Health Program Office by becoming the coordinating agency for health education, promotion and risk reduction services. One community health education risk reduction project is presently being funded and several communities have already submitted funding requests.

The Health Education Unit is also responsible for state funded projects. Presently, four pilot projects are being coordinated and monitored in three areas: Chronic Disease Control, Comprehensive Health Improvement, and Comprehensive Health Education Coordination. The projects are concerned with risk identification and reduction, community awareness, and formation of a learning house for the multi-county region. In May 1980, to develop health promotion and chronic disease prevention strategies, a Health Program Office Chronic Disease Strategy was developed. The major goal of this committee is to develop a Healthy People for Florida.

State expenditures to joint state-federal efforts in prevention rose from $12.9 million in FY 1978 to $14.7 million in 1980. These figures include prenatal and postnatal care, VD control, cervical cancer detection, TB screening and control, teenage pregnancy, communicable disease control, nutrition education and immunization.

In the area of alternatives to institutional care for the mentally disabled, state contributions to joint state-federal congregate living service programs reached $4.05 million in FY 1980. Independent state expenditures equalled $425,000 (supporting 4 small group homes) for the same services and $1.1 million for day care, $17,500 for foster care and $13,500 for transportation.

Florida is also considering statewide programming for Chronic Institutional Recividists made up of a composite of the following services: Residential Services including supervised and satellite apartments; Day Treatment Services designed to improve a client's ability to cope with daily living stresses, vocational opportunities, and social/recreational activity; Intensive Case Management Services performed by mental health professionals designed to provide individualized client assessment, treatment planning, monitoring, linking the client to other entitlements and client advocacy; Social services designed to provide social clubs and networks intended to reduce the isolation and withdrawal of this client population.

All districts, with the exception of those currently implementing deinstitutionalization pilot projects, are recommended to receive a minimum of one, maximum of three service systems, depending on target group discharge flow.

The FY 1981-82 phase-in implementation cost of one system is $590,109. The FY 1982-83 annualized cost of one system is $862,413. The statewide costs for the first year phase-in is $8,851,635. The statewide annualized costs to implement these systems during FY 1982-83 is $12,936,195.

The Family Placement Program mandated in Section 393.068, Florida Statutes, is a program that enables the retarded and other developmentally disabled persons to remain in a family setting, avoiding or reducing the necessity of placement in a more restrictive residential setting. It is designed to provide funds necessary to remove barriers and to obtain services and programs which are vital in meeting the client's habilitative needs. Each District is responsible for operationalizing these regulations with specific written instructions. The state supported 444 small group homes for the developmentally disabled through contracts for basic care and supervision ($9.3 million in 1979). $80,000 were also provided for renovation, conversion, or construction in the same year. In addition, the state contributes significantly to joint day care efforts and transportation.

The Chronic Care System for the Chronically Impaired Elderly is designed to coordinate non-institutional services and case management through the establishment of a comprehensive single entry system. The CCS project is also designed to identify and coordinate funding sources for elderly programs. The CCS concept is a continuum of integrated services ranging from the provision of specialized support services to facilitate independent living to the provision of a milieu of support services to maximize residential institutional care. The primary elements of this are Facilitator Service, Care Assessment Service, Geriatric Out-Patient Service and Aging Education and Training.

State funding for elderly service through joint efforts in 1980 were $196,000 for home health, $6.017 million for homemaker, $1.387 million for day care, $8.096 million for case management, $3.073 million for transportation. Additional independent state funds were allocated for transportation, home health and homemaker services.

## GEORGIA

Georgia has no hospital rate-setting or budget review plan nor is one pending in the legislature.

Blue Cross/Blue Shield activities such as benefit packages, composition or appointment to Board (a majority must be providers in each case), and Medigap benefits must be approved by the State Insurance Commission. Activities of Health Maintenance Organizations such as benefit packages, premium rates, and composition/appointment to the Board (which must include providers and at least one third be public members), also must be approved. For all other commercial carriers, benefit packages, Medigap benefits, and cancer insurance must be approved by the commissioner.

Georgia Certificate of Need agency monitors bed construction and capital investment on the basis of submitted documents and physical inspection. During FY 1978 and FY 1979, no instances of noncompliance with CON were detected. Available sanctions for noncompliance are fines, denial of licensure, and injunction. Outpatient hospital services are covered in CON and the coverage of specific diagnostic or therapeutic equipment regardless of location has been proposed. Georgia's CON program is currently considering proposals on a first come first served basis, but is planning to group proposals. There is no CON mechanims to decertify unneeded beds or facilities.

A mechanism to coordinate state health service needs with financial assistance decisions has been proposed in the present Preliminary State Health Plan. Georgia does not have a State Health Service Corps but does have loan programs with payback provisions. If the recipient leaves the program or does not complete the requirement of practicing in a qualified community in Georgia, he/she will be responsible for repaying the total amount plus interest to the state in 30 to 90 days. Between 1978 and 1980, an average of 37 students were enrolled in the program and an average of 16 individuals bought out of the program. Georgia also gives financial assistance to nursing and physician's assistant programs without the obligation of repaying the state through performance of services.

Health promotion and disease prevention are the responsibility of the Georgia Department of Human Resources, specifically the Division of Physical Health. The programs within this division include Maternal and Child Health, Dental Health, Environmental Health, Emergency Services, TB and VD Control, Family Planning, etc. At the state level, the division director and coordinating staff take charge of program direction and coordination. In FY 1979, 28.9% of the state's total population received services rendered by this division. Georgia has been increasing financial assistance in such state funded only programs as PKU testing, alcoholism intervention and epidemiology.

Hospitals and nursing homes in Georgia have technical assistance programs for licensure. Georgia has no evaluation mechanism for building, fire, and life safety code requirements for health care facilities.

There are several non-institutional alternatives programs for the mentally disabled, developmentally disabled and the elderly in the state of Georgia. A joint state and federal effort provides day training and activity centers for the developmentally disabled. State funded contracts ($1.4 million in 1980)

provide developmental training, family support homes and respite care for this same population. Finally the state subsidized ($2 million in 1979) 40 small group homes for the mentally retarded. For the mentally disabled, joint state and federal and state only programs focus on day care and foster care services respectively. The state also supports 90 self-help apartments (for mentally and developmentally disabled) and 25 board homes.

# HAWAII

Health and welfare programs in Hawaii are coordinated through quarterly meetings of respective departmental directors.

The Hawaii Prepaid Health Care Act requires employers to provide a minimum benefit package to their employees through prepaid health care plans rather than conventional third party insurance. These plans, which must include certain required benefits, are cleared with the Disability Compensation Division of the Department of Labor and Industrial Relations, which administers the Act.

The state of Hawaii currently has no enforced restrictions on advertising. A state statute prohibiting dental fee advertising is not enforced. The state also does not have requirements for the publication of health price information.

A system for monitoring bed construction and capital expenditures for compliance with Certificate of Need approved expenditures is now being tested. Sanctions to enforce CON currently include jail sentence, fine, revocation of license, denial of licensure and an injunction. The CON program currently covers outpatient hospital services, clinic services and specific diagnostic or therapeutic equipment. As structured the CON program groups applications for health care facilities or capital expenditures for equipment before selecting the most appropriate one. A swing bed policy was adopted by Hawaii.

Hawaii does not have laws, rules or regulations to license or certify family nurse practitioners and nurse psychotherapists. Under Hawaii law, the Board of Medical Examiners is authorized to adopt rules and regulations governing standards of training and education of physician's assistants but has not yet done so. It is estimated that at the end of FY 1980, seven nurse midwives will be licensed in Hawaii. The regulatory agency is the Department of Health and they are supervised by written protocols. The authority to prescribe, dispense and adminiter drugs is arranged by protocol between the physician and midwife.

In relation to specialty hospitals the state has adopted technical assistance programs for the licensure process. Cost benefit analyses, a public hearing and an appeals process for codes and regulations are included in the evaluation mechanism of the building, fire and life safety code.

In 1980, the state legislature appropriated $250,000 to the Department of Health for the development of community residential programs which provide alternatives to institutional settings for mentally disabled clients. Hawaii is also participating in the HUD/HHS special demonstration project for chronically mentally ill. In 1979, these federal funds were awarded to a private organization to develop an independent living complex of 10 units. This year another proposal for independent living has been submitted. The State of Hawaii also provides a growing amount of independent state funds for congregate living services for this population ($466,312 in 1980, more than double the 1979 figure).

# IDAHO

In coordinating health care cost containment policy across health and health related programs, the Governor's representative serves as a liaison to the Department of Health and Welfare and is responsible for all human service programs in the department. State health and welfare programs are coordinated through the State Board of Health and Welfare and department director cabinet meetings.

The state of Idaho has only just implemented a Certificate of Need program although such a program will be operational in October 1980.

Idaho's insurance commissioner must approve insurance benefit packages, medigap benefits, cancer insurance and the composition or appointment to the board of trustees of insurance carriers. All policy forms and contracts must be approved according to statutory requirements. Insurance carriers must file all requests for rate increases and must indicate that they are within the limits set by the President's anti-inflation program. In addition, loss ratios must be filed. Furthermore, although the Department of Insurance does not have the statutory authority to disapprove premium rates, the department does attempt to make a determination of whether or not the rates are excessive given the benefits being offered. The department also has promulgated a regulation on minimum standard requirements for all disability, hospital, and medical insurance.

For hospitals, interchangeable state licensure, voluntary accreditation and certification standards have been adopted. Idaho also accepts other states' surveys and certification recommendations for certified home health agencies and rural health clinics. Technical assistance programs for licensure of hospitals, nursing homes and rural health clinics is another measure that has been adopted. The building, fire, and life safety code requirements for health care facilities include an examination for duplication of other state codes or regulations, examination for inconsistency with other state regulations and cost-benefit analyses.

All financial assistance for residency programs is targeted for primary care residency programs. An average of $218,333 was allocated in each of Fiscal Years 1978, 1979 and 1980.

Four categories of allied health personnel--nurse midwife, nurse practitioner, nurse psychotherapist and physician assistant--are allowed to practice in Idaho. The State Board of Medical Examiners is the regulatory agency for physician assistants while the Board of Nursing regulates the other three groups. For nurse midwives, practitioners and psychotherapists supervisory requirements include supervision by telecommunication and written protocols. Physician assistants are supervised by both these methods as well as through the presence of the physician. Nurse midwives, practitioners and psychotherapists all have emergency authority for dispensing drugs and some authority for prescribing drugs. In 1980, an estimated total of 22 physician assistants and 121 nurse midwives will be licensed for practice.

The Division of Health currently has a great interest in health promotion and disease prevention. The Division has encouraged risk factor identification, the promotion of lifestyle changes toward improving long-term healthful living,

and has encouraged programs through district health departments and private industry to promote healthful living and change self-destructive lifestyles. The Division of Health program has, at this time, not been funded, but successful grant applications have been written and funds received in the Bureau of Consumer and Health Education. These applications have concentrated on accident prevention, hypertension control, and risk factor modification, and the Bureau of Consumer and Health Education has assigned staff responsibility for health promotion, accident prevention, and risk factor modification.

Currently, the Governor's Project Independence Task Force is preparing recommendations to develop the mechanism to coordinate non-institutional long term care services. Recommendations will be submitted to the Governor in December 1980.

The Idaho State Senior Services Act provides direct funds for homemaker and chore services for the elderly population ($108,158 in 1980) and $99,554 for transportation. In joint state-federal efforts, Idaho provided $673,699 in FY 1980 for Title XX homemaker services and day care.

# ILLINOIS

The Human Services Subcabinet, staffed by the Governor's office, coordinates Illinois' health care cost containment policy. This Subcabinet has monthly meetings of all agency directors to plan and coordinate state health and welfare programs.

Illinois' rate-setting body began in 1978 but rates are not expected to be set before 1981. The proposed program will be mandatory and will cover Blue Cross, Medicaid, Medicare (waiver requested) and other commercial and individual payors. The proposed program will be administered by an independent commission. It would generally set, prospectively, a fixed rate of allowed increase in charges and in some cases, variable rates for charges according to hospital characteristics. The start-up administrative costs of the program were $200,000 in FY 1979 and an estimated $650,000 in FY 1980.

The state requires approval of the following activities of health insurance carriers. Benefit packages including all contracts, certificates, and forms must be approved by the Department of Insurance for Blue Cross, HMO's and other commercial carriers. Concerning premium rates, Blue Cross must be approved prior to use and can be disapproved if a coporation has not made a "good faith" cost containment effort; HMO's must be approved prior to use with a 45-day limit. Composition of the Board is governed by statute for all three. For Blue Cross and HMOs, the board must conform to requirements on the percentage of providers serving as board members. A statute enacted in 1980 gives the insured an unconditional money back guarantee for Medigap policies offered by Blue Cross/Blue Shield, requires an outline of coverage, and mandates premium refunds where policies are duplicative or inappropriate gives current coverage.

Finally, general advertising form approval is required by commercial carriers offering cancer insurance. According to Illinois statute patients have a right to examine and receive a reasonable explanation for hospital room charges, physician fees, ancillary service costs from any public or private facility. Physicians, dentists, psychiatrists and non-physician practitioners may advertise only certain information such as name, address, office hours, and fees for routine services. No testimonials or claims of superior quality care may be used.

In the medical manpower area, the state of Illinois has adopted a loan program with payback provisions. Individuals repay in service year for year for each year of support--maximum of three years. The penalty for disenrollment is three times the loan amount. Currently 40 students receiving $325,000 are enrolled in the program. In addition, the state is considering the development of a state health service corps. In providing institutional support for residency training state assistance, $1.13 million in 1980 was targeted for primary care residencies; of that amount $456,000 was for family practice. The state also heavily supports nursing education ($20 million in FY 1980) through assistance to colleges, universities, and hospitals.

Illinois has no special licensing classification for nurse midwife, family nurse practitioner and nurse psychotherapist. Physician assistants are certified for practice in the state given successful completion of a specialized course for PAs approved by the Committee or Allied Health Education and

Accreditation of the American Medical Association Council on Medical Education and a written examination. The State Board of Medical Examiners is the regulating agency. A physician may supervise no more than one PA. The physical presence of the physician is not required for supervision of the PA, although supervision by telecommunication is. PAs in Illinois may not prescribe, order, or dispense medication unless specified in written protocols approved by the Department of Registration and Education.

Prior to the 1979 legislation, licensing measures for nursing homes were the same as the federal standards. However, this is no longer the case. Hospital facilities in Illinois are simultaneously inspected for licensure and certification. There is some phase-in of requirements for both hospitals and nusing homes. Illinois does have an evaluation mechanism for building, fire, and life safety code requirements for health care facilities. This includes examination for duplication and inconsistency and public hearing or comment. Cost/benefit analysis is used by the Department of Public Health although it is not binding on any other agency. The administrative rule-making process allows public comment and review for legislative intent.

Coordination of state efforts on health promotion and disease prevention can take place in two ways. Two or more agencies may work out agreements concerning problems which require the expertise and resources of more than one agency. Also, the Governor's Subcabinet provides a channel for which "related" agencies or departments can pool efforts and resources on solving problems. Independent state efforts in prevention have focused on TB and communicable diseases control.

Joint federal-state program efforts in alternatives to institutional care for the elderly have focused on the provision of homemaker and other chore services (totalling $9,157,404 from both sources in 1980). Independent state efforts in transportation and day care exceeded $800,000 in 1980.

# INDIANA

Indiana does not have a state enacted hospital rate setting or budget review program.

Indiana's insurance code requires all policies and forms offered by Blue Cross, HMOs and commercial carriers to be filed with the state insurance commissioner for approval. Further, rates must be reasonable for benefits provided. The state has the right to disapprove within 30 days after the date filed. Composition of the Board is governed by statutes pertaining to mutual companies. Stockholders shall elect same and file evidence of those elected with the Insurance Department.

Certificate of Need rules are currently being drafted in Indiana.

Indiana has very few special purpose health education manpower programs because there is only one publicly-funded medical school in the state. The state can influence medical training directly through the appropriations process. There are no loan programs nor a State Health Service Corps.

Indiana licenses both nurse midwives and physician assistants for practice in the state. Nurse midwives and physician assistants must be examined by the practitioner's association and must have educational approval by a state agency. The State Board of Medical Examiners is the regulating agency for both groups of allied health professionals. The physical presence of a physician is required for supervision of PA's. Supervision by telecommunication is sufficient for nurse midwives. Physician assistants and nurse midwives may not administer, dispense, or prescribe drugs except under emergency conditions.

The Indiana Hospital Licensure Council has agreed to joint surveys if invited by the hospitals. Two surveys were completed in this fashion. Licensure and certification surveys are coordinated for hospitals and nursing homes. Technical assistance and consultation is provided to hospitals as part of the survey and on program operation. Design concepts are part of architectural plan review. Indiana uses the NFPA Life Safety Codes and National Bureau of Standards Equivalency Evaluation.

The State Board of Health has responsibilities as Indiana's public health department and as its state Health Planning and Development Agency. In the latter capacity, the Board coordinates efforts in the fields of health promotion and disease prevention.

State efforts to date in the area of alternatives to institutional care for the mentally and developmentally disabled have focused on the provision of congregate living services. These services received in excess of $1 million from the state in FY 1979 and FY 1980. In addition the state provided over $2.5 million in FY 1980 for foster care services for the elderly and mentally disabled. The State Assistance to Residents in County Homes program provides cash assistance to certain eligible blind, aged, and disabled persons residing in County Homes. In Indiana these "boarding" homes are licensed health care facilities. A bill is currently under consideration in the Senate which would establish demonstration projects designed to examine the coordinated delivery of home health and personal care services.

Health care cost containment policy and health and welfare programs are coordinated by the Governor's administrative assistant who serves as a liaison between the Department of Social Services and Department of Health.

Bed construction and capital investments are monitored for compliance with Certificate of Need limits by intermediaries at the time of reimbursement audit and by survey/self reporting to the licensing division. Sanctions available for violation of CON limits include suspension of license, denial of reimbursement and court injunction. Iowa has adopted a swing beds program on a demonstration basis.

Iowa's insurance commissioner is charged with approving insurance benefit packages offered by Blue Cross/Blue Shield, health maintenance organizations and other commercial carriers. Premium rates of Blue Cross/Blue Shield and health maintenance organizations also require the commissioner's approval. The composition of or appointments to the board of trustees of health maintenance organizations must also be approved as well as medigap benefits offered by Blue Cross/Blue Shield and other commercial carriers. Cancer insurance policies of commercial carriers must also be approved by the commissioner. In addition, the Iowa legislature allows the insurance commissioner to promulgate rules on minimum standards in individual and subscriber contracts. This law became effective in July of 1980 although no regulations have been adopted. It is expected that the new regulations will address benefit packages, minimum loss ratios, medigap, cancer and other issues.

Public information regulations in Iowa require that information on drug costs and the qualifications of physicians and non-physician personnel be made public. Such personnel qualifications, excepting grades, are public information in the hands of the Board of Medical Examiners or the appropriate licensing board. Dentists are prohibited from advertising when the media being used does not offer similar opportunities to all dentists.

For hospitals, interchangeable state licensure, voluntary accreditation and certification standards have been adopted. Other types of coordination between licensure, accreditation and certification surveys have also been adopted for nursing homes. Technical assistance programs for both hospitals and nursing homes have been implemented to assist facilities through the licensure process. An appeals process for the evaluation of building, fire and safety codes for health care facilities is currently active.

Physician assistants are licensed to practice in Iowa and are regulated by the State Board of Medical Examiners and the Physician Assistants Examiner Committee. Supervision requirements mandate telecommunication contact with a physician and written protocols. Regulations prohibit physician assistants from prescribing drugs but do grant them some administering and dispensing authority.

Iowa established in 1980 a health promotion-risk reduction program with the purpose of assisting state and local health agencies in initiating, strengthening and delivering health education programs. Emphasis is placed on educating citizens about their personal behavior and choices so as to reduce premature death and disability associated with cigarettes, obesity, hypertension and other

chronic diseases which are preventable. In Fiscal Year 1980 Iowa spent an estimated $5.6 million on meals on wheels and congregate services for the elderly. Nutrition education for the elderly and pregnant women was allocated $7.4 million, while prenatal and postnatal care received approximately $1 million. Venereal disease control, PKU testing, teenage pregnancy and children and youth projects each received approximately $0.5 million. Other programs to which funds were allocated include immunization, hypertension screening, occupational alcoholism intervention, perinatal care, TB screening and control, communicable disease control and early and periodic screening and diagnostic testing. In all, an estimated total of $17.3 million in state funds was allocated to disease prevention programs.

Iowa participated in several programs designed to provide non-institutional services for the mentally and developmentally disabled. Both state and federal Title XX funds supported home health, homemaker day care and social services, foster care and transportation (totalling $231,459 for the mentally disabled and $843,755 for the developmentally disabled in 1980). The elderly received the same services--expenditures exceeded $8.5 million.

The state also supports an In-Home Health Care project for the elderly which received over $3 million during FY 1980.

## KANSAS

Kansas' cost containment policy is coordinated by Governor's Policy Council which focuses on hospital cost containment and a liaison person between the appropriate agencies and the Governor's office. A proposal for a hospital budget review program died in the 1980 legislative session. However, Kansas does have such a program for the nursing home program under Medicaid.

All insurance or idemnity contracts are required by law to be filed with approval by the insurance commissioner before being placed in the market. Premium rates offered by Blue Cross/Blue Shield and health maintenance organizations must be approved by the commissioner. The rates are required to be reasonable, adequate and not unfairly discriminatory. Rates utilized by commercial carriers must be reasonable in relation to the benefits provided. In the case of commercial carriers, rate regulation is achieved through the approval or disapproval of the forms with which they are used. Composition of and appointment to the board of trustees of health maintenance organizations also require the commissioner's approval. Specific approval is not required for the board of trustees of Blue Cross/Blue Shield or commercial carriers; however, composition of the board of directors of domestic organizations is prescribed by statute. Medigap and cancer insurance offered by all three types of organizations require the commissioner's approval and the forms and rates are regulated by the statutory requirements applicable to health insurance coverage generally. This includes not only the authority to approve but also to advertise regulations, minimum benefit standards, ten days free look at individual policies, outline of coverage requirements or individual policies as well as regulations on deceptive practices.

In order to monitor bed construction and capital investments approved by the Certificate of Need program, project sponsors are required to submit progress reports at least annually and to file amendment requests if there are changes in project scope. The Secretary of Health and Environment may enjoin the undertaking of a project which does not have CON approval or in the case of a violation of CON guidelines reimbursement may be denied. The CON program also covers outpatient hospital services and when undertaken by a health facility, clinic services and physician office services. Coverage for specific diagnostic or therapeutic equipment used in inpatient health facility services is proposed.

Physician assistants are allowed to practice in Kansas and are regulated by the State Board of Healing Arts. From fiscal year 1978 to 1980, 308 physician assistants have been licensed in that state.

Measures to coordinate licensure, accreditation and certification of nursing homes have been adopted. The evaluative mechanism for the building, fire and life safety code for health care facilities includes cost-benefit analyses, public hearing and an appeals process for codes and regulations.

Operating in Kansas is a health promotion program, "PLUS," to lower utilization of services through emphasis on exercise, weight, diet, smoking and stress. Joint state-federal health prevention programs that have received funds include perinatal care, venereal disease control and cervical cancer detection, and PKU testing, hypertension screening, immunization and children and youth projects. The state also independently funds a hypothyroid testing program.

In the area of alternatives to institutional care the state operates two programs "Partnership Agreement for the Continuity of Treatment (PACT)" and "Community Placement." PACT is a community mental health screening program designed to prevent unnecessary utilization. "Community Placement" brings together state and local resources, and Title XX and Vocational Rehabilitation funds in efforts to place deinstitutionalized patients in the community. This program also includes developmentally disabled persons who have not been previously institutionalized.

## KENTUCKY

Bed construction and capital expenditures approved by the Certificate of Need program are monitored through six month progress reports. The program also receives inquiries from the Department of Health and Human Resources on facility audits. During Fiscal Years 1978 and 1979, 17 and 10 instances, respectively, of noncompliance with CON were detected by the monitoring mechanism. Sanctions available for noncompliance are fines, denial of reimbursement and denial of licensure. Reimbursements were denied 14 times in Fiscal Year 1978 and denied 9 times in FY 1979. Also covered under the CON program are outpatient hospital services and clinic services. Applications received by the CON program will be grouped in the selection process. Kentucky also has adopted on a demonstration basis consolidation into the HSA health plan of other categorical health plans.

Benefit packages offered and the composition of and appointment to the board of trustees of Blue Cross/Blue Shield and health maintenance organizations require the insurance commissioner's approval. Premium rates and medigap benefits offered by the above-mentioned organizations, as well as commercial carriers, also require the commissioner's approval. For Blue Cross/Blue Shield, the Insurance Department has approved a rating formula and trend factors which the department then uses to base its approval or disapproval. Cancer insurance policies are sold by commercial carriers, but not by health maintenance organizations and Blue Cross/Blue Shield. As to commercial carriers, all individual single contracts are required by the Insurance Department to have a minimum 65 percent loss ratio for new plans.

Restrictions on advertising in Kentucky apply to physician fees, dental care fees, psychiatric care fees and non-physician practitioner fees.

All licensure and certification surveys are done simultaneously whenever possible. Technical assistance programs for licensure are available for hospitals, nursing homes and rural home clinics. The safety code requirements for health care facilities include an examination for duplication of other state codes or regulations, examination for inconsistency with other state regulations, a public hearing and an appeals process for codes and regulations.

Nurse midwives and family nurse practitioners are licensed to practice in Kentucky. Both are regulated by the state Board of Nursing and supervision is by written protocol. In 1980, 15 nurse midwives and 50 family nurse practitioners will be licensed to practice.

The Health Education Unit in the Bureau for Health Services is conducting a health education-risk reduction program. The program is designed to demonstrate that medical self-care education can influence personal choice behaviors that reduce the risk of developing certain diseases and can provide the capability for self-care in the treatment of routine health problems. A community approach is used and the primary target groups are pregnant women and primary and intermediate school students. State expenditures for joint state-federal preventive health programs from Fiscal Year 1978 to 1980 annually have averaged $6.8 million for perinatal care, $1.9 million for TB screening and control, $5.7 million for children and youth projects and $14.2 million for nutrition education of the elderly, children and pregnant women. Other programs which have received funds include venereal disease control, cervical cancer detection, communicable disease control, immunization and hypertension screening.

The Council on Higher Education has the statutory authority to approve or disapprove all programs in public higher education in Kentucky. A study of graduate medical education needs will be completed in 1982. In 1970, the state mandated the development of Family Practice Residency programs at the two medical schools. In 1976, Primary Care Residencies programs and support for students were implemented. The purpose of this program was to reduce the discrepancy between the number of residency positions and number of medical school graduates, thereby reducing exportation. Nearly all state support to institutions for residency programs is for primary care and family medicine. The Kentucky Rural Medical Scholarship fund offers loan forgiveness to medical students who practice in critical counties (physician shortage areas) or the public health service. Students who practice in a non-critical rural county may also receive loans but must repay after one-year service. State allocations to the fund were $150,000 in 1979. Sixty-nine students are currently enrolled.

The state also funds teaching institutions for the support of FNP, PA and RN programs.

## LOUISIANA

Louisiana's state health and welfare programs are coordinated by the Governor's liaison with the Health and Human Resources Agency. There is no formal mechanism for the coordination of health care cost containment.

Bed construction and capital investments are monitored for compliance with Certificate of Need approved limits through periodic reporting to the Department of Health Planning and Development by applicants, by coordination with the Division of Licensing and Certification and the various HSAs. It has also been proposed that CON coverage be extended to outpatient hospital services and specific diagnostic or therapeutic equipment regardless of location.

The state of Louisiana does not have or anticipate a hospital rate-setting program. However, it does limit state reimbursement to nursing homes.

State insurance regulation requires the commissioner's approval for cancer insurance policies offered by Blue Cross/Blue Shield.

Consumer information regulations require that the qualifications of physicians and non-physician personnel be made public records. The advertising of physician fees, dental care fees and drugs are restricted by state statute. However, while the authority for regulating these restrictions exist, no regulations have been promulgated by the State Board of Medical Examiners. Drug retailers are prohibited from referring inaccurately in its advertisements to competitors' products. Retailers are further prohibited from giving secretly to an employee, agent or customer an item of value for the purpose of influencing a sale, sell merchandise at less than cost, or render an inaccurate bill of account.

Physician assistants and family nurse practitioners are respectively certified and licensed to practice in Louisiana. The following summary on FNPs is based on rules and regulations the Board of Nurse Plans to adopt in the near future. The State Board of Medican Examiners regulates physician assistants while the State Board of Nursing oversees family nurse practitioners. Nurse practitioners are supervised by written protocols and have limited authority to administer drugs. A physician must be available within 30 minutes to a practicing physician assistants and PAs are prohibited from prescribing drugs. In Fiscal Year 1980 a total of 130 family nurse practitioners and 81 physician assistants were licensed to practice. Furthermore, proposed rules and regulations in Louisiana suggested the adoption of several new categories of advanced practitioners of nursing including primary nurse associate (also known as nurse practitioner). A primary nurse associate is a registered nurse providing acute or chronic care to families, individuals or groups in a variety of settings. The goal of such care is the achievement, maintenance or restoration of essential activities of daily living. Certified nurse midwife is the second proposed category. A certified nurse midwiffe is also a registered nurse who, through additional knowledge and skill, has extended her practice to the management and care of mothers and babies. Certified registered nurse anaesthetist is the third category and providers anaesthesia care. The final proposed category is a clinical nurse specialist who is a registered nurse with a masters degree specializing in one area of clinical nursing. The functions of a clinical nurse specialist are direct and indirect nursing care, research,

change-agent, teaching and consultation. A clinical nurse specialist would therefore provide direct care as well as direct and evaluate the care being rendered by others, teach, investigate new methods of nursing intervention and health care and act as a catalyst and/or initiator of change and a resource guide to others involved in health care delivery.

The small group homes (under 16 beds) which are state operated in Louisiana generally have capacities of six or more. The majority of clients served are mildly mentally retarded adults, although a few of these group homes are for emotionally disturbed, learning disabled or multi-handicapped individuals. The majority of these facilities are located in Region I (New Orleans), Region II (Baton Rouge), and Region VII (Shreveport), and the remainder are scattered among the other five regions of the state. The reimbursement rate for clients residing in these group homes varies widely, ranging from approximately $20 to $60 per day for each person. The state subsidizes 20 such facilities receiving a total of $2.2 million in 1979.

The state legislature is also considering a $310,000 appropriation for the development of community support programs for mentally disabled clients. The state has requested funding for a number of alternative programs over the past three years.

## MAINE

The Department of Human Services Voluntary Hospital Cost Containment Program coordinates state efforts in this area. This hospital budget review program was enacted July 1, 1978. The first budget reviews were carried out for facility Fiscal Years beginning on or after July 1, 1979. No significant changes have been made in the budget review portion of the law and no changes are pending legislative enactment.

Benefit packages offered by Blue Cross/Blue Shield, health maintenance organizations and other commercial carriers are subject to the insurance commissioner's approval. Medigap and cancer insurance policies offered by the three categories of carriers are subject to the same policy form requirements as other health insurance products. Prior approval of rates offered by health maintenance organizations is not required. However, the rates are a crucial factor in regulating the overall financial picture of the HMO, so that the insurance commissioner does have indirect rate control. Blue Cross/Blue Shield and private carriers do not receive prior approval of individual health insurance rate filings. Rate filings are made and, subject to procedural rules, new rates may be used. Statutory procedures exist for subsequent review and disapproval by the Maine Superintendent of Insurance. Composition or appointment to Board of Trustees of all three insurance groups are covered by various sections of Title 24 which covers the composition and identification of all corporate boards, directors, officers, trustees, and other principals.

In an effort to contain health care costs, the Health Facilities Information Disclosure Act mandates disclosure and analyses of facility cost information. That law, which established the budget review system discussed earlier, was enacted in 1977. Another state law requires health maintenance organization plans to be made available to the public. Only one restriction on advertising pertaining to controlled narcotics exists in the state. Advertising prices of pharmaceuticals with this exception is permitted.

Legislation authorizes the Department of Education to subsidize seats out of state to be occupied by Maine students for a joint purpose: (1) provide access to post-graduate health professions education; and (2) to provide manpower for the state. This mechanism is a contract whereby the student who occupies the seat subsidized by the state agrees to return to practice in the state. The seat subsidy goes directly to the medical school to subsidize the total cost of education. Students do not receive financial assistance, except in limited amounts; however, those under contract are required to pay back in services half of total cost to educate. If they dropped out of the program they must repay 100% plus interest. The state does not assist the student in meeting tuition or other expenses. A proposal is under consideration which would require service payback in underserved areas rather than merely returning to the state.

Family nurse practitioner and physician assistants are licensed to practice in Maine. The State Board of Nursing and State Board of Medical Examiners regulate nurse practitioners and physician assistants, respectively. Physician assistants are supervised by telecommunication and written protocol whereas nurse practitioners are supervised only through written protocol. Both nurse practitioners and physician assistants are allowed some authority to prescribe,

dispense and administer drugs. In Fiscal Year 1980, 21 physician assistants were licensed to practice.

For hospitals and nursing homes, interchangeable state licensure and certification standards have been adopted. The building, fire and life safety code evaluation requirements for health care facilities include a public hearing and an appeals process for codes and regulations.

State efforts in the areas of health promotion and disease prevention are conducted as a part of several programs within the Bureau of Health in the Department of Human Services. Maine also funded preventive programs focusing on radiological/occupational health, drinking water, waste water/plumbing control, diabetes control and genetic diseases. In addition to joint federal and state prevention programs, Maine independently funds a Medical Eye Care and a Community Environmental Program.

In the area of alternatives to institutional care Maine provides residents of small group homes for the elderly, mentally disabled, and developmentally disabled state dollars without federal match to supplement payments from the SSI program. Several regional programs designed to provide specific services have been developed.

In one rural Maine county, a program was developed to meet short-term emergency needs where there are no home delivered meal sites and where distance precludes meal deliveries. Outreach workers arranged with a neighbor or the nearest village restaurant to prepare and deliver a daily meal for a period not exceeding 3 weeks. Hospital discharge cases and/or short-term temporary illness needs are thus met.

Southern Senior Citizens in Maine entered into a subcontract with homemaker services to provide services during evening hours and weekends (i.e. assistance in undressing, going to bed, etc.) because normal 8-5 homemaker hours do not meet these specific needs. They also have an intergenerational program to accomplish basic home chores. This is in conjunction with CETA using teenagers. There is a heavy demand and a waiting list for this service and income eligibility is not a criterion.

The Muskie Senior Center in Waterville is a nutrition site. It has been enlarged to accommodate handicapped elderly, who are borderline cases, broaching institutionalization, and living with relatives who are employed. The staff is composed of a social worker who coordinates services and resources, a site director, an advocacy director and 2 advocacy aides. By providing special transportation, assistance and special attention, the clients are able to attend the center 2-3 days a week--reducing the need for home services on those days. Doctors cooperate with the individual care plans.

Mobile elders help as support groups with social activity after talking with the handicapped clients on days they are home bound, visiting, or playing cards, etc. when at the site. About 60 handicapped elderly are serviced. Average attendance is about 25 frail persons per day. Educational programs and counseling are provided.

## MARYLAND

Coordination of cost containment policy across health and health-related programs is conducted by the Maryland Health Services Cost Review Commission, the state's rate-setting mechanism for hospitals. The Commission is located within the Department of Health and Mental Hygiene which reviews all local health budgets to approve matching expenditures for state aid. This broad area of responsibility minimizes the need for inter-departmental coordination that would otherwise have to take place through the Governor's office or other means.

Since 1971, the rate review program has undergone three changes: 1) addition of conflict of interest reporting requirements by hospital trustees; 2) inclusion of nursing homes in jurisdiction; and 3) alteration of review procedures. Short stay hospital expenditures in 1978 were $958 million, $1.1 billion in 1979 and will be an estimated $1.2 billion in 1980, or an annual increase of 14.5 percent from 1978 to 1979 and 11.3 percent from 1979 to 1980.

The Certificate of Need program includes a mechanism to monitor approved limits on bed construction and capital investments. Sanctions available for violation of CON limits or other state guidelines are suspension or revocation of licensure, denial of licensure and injunction. None of these sanctions were imposed in 1978 or 1979. The CON program also covers outpatient hospital services, clinic services and specific diagnostic or therapeutic equipment for provision of services to inpatients. Applications for new health care facilities or capital expenditures to the CON program are currently considered on a first come first served basis; however, the program is planning to group proposals.

Benefit packages, premium rates and medigap benefits offered by Blue Cross/Blue Shield, health maintenance organizations and other commercial carriers require the approval of the insurance commissioner. Cancer insurance offered by commercial carriers also requires approval. Generally, approval entails a finding that the benefits and premiums are in reasonable relation to one another, the policy forms and coverage include the provisions and benefits required by statute, and the policies are not misleading, ambiguous or of insufficient economic value.

Under Maryland law a hospital or related institution must provide certain financial statements which are available to the general public. A patient is entitled to receive upon request, from either type of institution, a bill which itemizes the fees charged by the physician, a breakdown of services rendered by non-physician personnel, ancillary care costs, and hospital room charges. Maryland code does not require individual providers to make available to the public information on physician fees or non-physician practitioner fees, nor is there a requirement to reveal the qualifications of physicians or non-physician personnel. However, several other statutes do mandate public disclosure for pharmacies, certain state facilities and HMOs. For example, the State Board of Pharmacy is required to compile a list of the 100 most commonly used drugs and their prices and to display this list in a prominent place. Health maintenance organizations are required to make available to the general public certain listed information. Further, the Maryland Public Information Act may apply to certain state run facilities and result in greater public access to their information.

Health maintenance organizations are allowed to advertise under Maryland statute. However, there is a restriction upon any advertisement that includes qualitative judgments concerning health professionals who provide services for an HMO. Advertisements by physicians or psychiatrists are prohibited unless the Board of Medical Examiners has provided for the advertisement in its regulations. Dentists are prohibited from advertising except for public notification by any dentist about to begin practice. There are no specific sections of the code that regulate the advertising by midwives, nurses, or optometrists.

Simultaneous inspection of hospitals by state surveyors and the Joint Commission for the Accreditation of Hospitals, as well as other types of coordination between licensure, accreditation and certification surveys for nursing homes, have been adopted. Phase-in of requirements for hospitals and nursing homes assist those facilities where immediate compliance is difficult. The evaluation mechanism for safety code requirements for health care facilities includes an examination for duplication of other state codes or regulations, an examination for inconsistency with other state regulations, a public hearing and an appeals process for codes and regulations.

Maryland is considering a proposal to coordinate state health service needs as identified through the state health plan with decisions on financial assistance to medical students, programs and teaching hospitals. This plan would require the State Board for Higher Education to identify areas with a shortage of nurses and to make funding recommendations. The State Scholarship Board would also interact with the medical community to identify student assistance needs. The Maryland State Grant Program provides funds for family physicians with a forgiveness of debt if practice is established within the state. A family physician who fails to complete in-state service must pay back the principal of the debt and interest at 7 percent. A special grant of $15,000 was made to institutions offering family practice residency in Fiscal Years 1978, 1979 and 1980. Residency programs are certified by the Medical Board although the type of physician residency program or number of individuals in the programs are not regulated by the state. The state provided directly to physician assistants $100,000 in 1978, $60,000 in 1979 and $90,000 in 1980 for education and training. These funds were awarded through the scholarship board to institutions for students.

Nurse midwives are licensed and physician assistants are registered for practice in the state. The State Board of Nursing regulates nurse midwives while the State Board of Medical Examiners regulates physician assistants. This latter group is supervised through written protocols and the physician on the premises. Both groups have been granted limited authority to administer drugs. In FY 1980, 80 physician assistants (a small decrease in registration over previous year) and 27 nurse midwives will be registered or licensed in the state.

Within the Maryland Department of Health and Mental Hygiene is the Preventive Medicine Administration whose goal is to evaluate, predict and prevent adverse health conditions, and to ensure the health of the citizens of Maryland. Some of the divisions within the administration also have as their goal health promotion and disease prevention. One such program is conducted by the Division of Maternal Health Care and Population Dynamics, under which prenatal, postnatal and perinatal care is provided, as well as services to promote community, adolescent sexual and family life education. The Division of Communicable

Diseases is responsible for the prevention and control of infectious diseases in Maryland. The venereal disease program has as its objective not only the control of sexually transmitted diseases, but the development of an educational program directed principally toward informing adolescents and young adults of sexually transmitted diseases, with special emphasis on prevention. An immunization program within the administration is geared to the control of all vaccine-preventable diseases, emphasizing that immunization against disease is probably the most cost effective means for prevention of disease. Within the aging and chronically ill sections of the department are several divisions also responsible for health promotion and disease prevention. Among these are the Division of Hypertension and Cardiovascular Disease Control, with the responsibility for assisting local agencies in developing and implementing high blood pressure control programs. In the Division of Respiratory Diseases major emphasis is placed on the control and management of tuberculosis and chronic lung diseases. Within the Cancer Control and Cervical Cancer Detection unit is a statewide program to implement cervical cancer screening, thus permitting early diagnosis, prevention, and effective therapeutic management of cancer. Heavy emphasis has been placed on a nutritional program in the Preventive Medicine Administration whereby women, infants and children are provided special supplemental food in order to prevent conditions attributable to nutritional deficiencies. In the Hereditary Diseases Division is a program to screen infants at the earliest possible moment to detect hereditary or metabolic disorders which can be substantially alleviated or treated, preventing the infants from becoming mentally handicapped or retarded.

State allocations to joint state-federal programs on prenatal care exceeded $1 million in each Fiscal Years 1978, 1979 and 1980, while children and youth health projects exceeded $4 million each year. Funds for immunization increased from $242,000 in Fiscal Year 1978 to $494,000 in 1980, communicable disease control from $100,000 in 1978 to $158,000 in 1980, and for teenage pregnancy from $117,000 to $158,000. An annual average for Fiscal Years 1978, 1979 and 1980 of $258,000 was provided for hypertension screening, $285,000 for cervical cancer detection, $362,000 for venereal disease control, $86,000 for hypothyroid testing and $820,000 for TB screening and control. Maryland supported a $266,200 perinatal care program in 1980. Additional state funds for independent state programs on nutrition education for pregnant women rose from $89,358 to $110,149 and for nutrition education for children from $46,000 to $50,000. EPDST outreach efforts have doubled since 1978.

The state match for Title XX funded homemaker and community home care services for the elderly was $1.2 million in 1980 and $165,000 for day care.

Maryland's Geriatric Evaluation and Community Placement Programs (receiving $300,000 in state funding in FY 1980) provide a limited form of case management. Other case management activities cannot be separated from other budget items.

The state provided $439,964 for congregate living services for this population group and $487,730 as supplements to individuals in domiciliary care and operating a family support program.

For the developmentally disabled, the state provided support in 1980 of $268,186 and $157,863 for foster care and transportation respectively. The bulk of state only funds, however, was for congregate lving services ($5.237 million in FY 1980). The state acquired 5 boarding homes and supports an additional 20. Finally, the state provided $162,286 to assist in the renovation, conversion, and construction of boarding facilities for the developmentally disabled.

## MASSACHUSETTS

Health care cost containment is coordinated by the undersecretary for Planning in the Executive Office of Human Services.

Massachusetts has had a hospital rate-setting program since 1976. Currently a new hospital charge control proposal is before the state. This hospital charge control legislation will place an 11.5 percent cap during the next year on hospital rate increase. The law will also create a one-year moratorium on the Rate-Setting Commission's charge control regulation and provide for a special commission to recommend comprehensive reforms in the hospital rate structure by next summer. The 19-member commission will include representatives of the legislature, consumers, hospitals, labor, regulatory agencies and the health insurance industry. The proposed program will be mandatory and would cover commercial and individual payors. Budget review would occur annually and would set a fixed rate of allowable increase in charges.

To assure compliance with Certificate of Need approved limits on bed construction and capital expenditures, the Massachusetts CON program has a designated compliance director and compliance analyst who require updated cost and square footage figures on all approved CONs. They communiate with hospitls on these issues during the post-CON approval process. Violations of the CON or other state guidelines render the violation liable for sanctions including the suspension, revocation or denial of licensure. The CON currently covers clinic services and outpatient hospital services and specific diagnostic or therapeutic equipment are under consideration for coverage. Proposals received by the CON program are currently grouped for comparison purposes before a selection is made.

Blue Cross/Blue Shield Medicare supplement benefits and rates, other individual policy benefit packages and rates as well as the composition or appointment to the board of trustees require prior approval. Benefits and rates for group policis can be filed and then implemented, however, they are subject to subsequent disapproval after a hearing. Benefit package, premium rates and medigap benefits offered by health maintenance organizations are subject to prior or subsequent disapproval after being filed and implemented. Other commercial carriers' benefit packages, premium rates, and medigap benefits on individual policies are subject to prior approval within 30 days and subsequent disapproval after hearing. Group policies can be filed and implemented and are subject to subsequent disapproval after a hearing. In regards to cancer insurance the issuance of individual accident and health policies purporting to provide coverage for cancer only is prohibited by regulation.

Simultaneous inspection of hospitals by state surveyors and the Joint Commission for the Accreditation of Hospitals is presently being negotiated. Currently there are other types of coordination between licensure, accreditation and certification surveys for nursing homes in addition to technical assistance programs for licensure of hospitals, nursing homes and rural health clinics.

Nurse midwives, family nurse practitioners, nurse psychotherapists and physician assistants are allowed to practice in Massachusetts. Except for physician assistants, all are regulated by the State Board of Nursing. All four categories are supervised by written protocols with physician assistants being

additionally supervised by telecommunications. Each group is prohibited from prescribing drugs. However, physician assistants have some administering and dispensing authority. In FY 1980 it is estimated that 28 nurse midwives, 900 family nurse practitioners and 120 nurse psychotherapists will be licensed.

The Massachusetts Department of Mental Health experienced clear reductions in the State Psychiatric Hospital population (from 3,500 in 1977 to 2,200 in 1980) and at the State Schools for the developmentally disabled (from 5,150 in 1977 to 4,400 in 1980). Expenditures for state hospital services have decreased as well. In addition, a major Federal Consent Decree has been signed ensuring adequate community services for the mentally ill. The state supports 163 small group homes for the mentally disabled and 276 homes for developmentally disabled clients (the elderly disabled clients are included). State Mental Health Department expenditures for day care and other social services for these client groups will exceed $24.5 million in 1980.

## MICHIGAN

The Office of Health and Medical Affairs in the Department of Management and Budget serves as the coordinating agency for discussions related to health care cost containment policy, with the Department of Social Services (State Medicaid Agency) being deeply involved in these discussions.

In Michigan, benefit packages offered by Blue Cross/Blue Shield and other commercial carriers require the commissioner's approval of the certificates and riders which implement the benefits offered. HMO law specifies certain basic benefits, and certain optional benefits are listed. Approval is required on premiums for Blue Cross/Blue Shield and commercial carriers insurance rates for individual policies. The rates of health maintenance organizations go into effect 60 days after filing if not disapproved. Medigap benefits for all three insurers and cancer insurance from commercial carriers also require approval.

To monitor compliance with Certificate of Need authorized bed construction and capital expenditures, unscheduled, periodic investigation of construction projects has been proposed for the CON program. Sanctions available for violations of CON expenditure limits or other state guidelines are denial of reimbursement and injunctive action. In FY 1979 denial of reimbursement was implemented five times and injunctive action sought twice. Outpatient hospital services and clinic services are covered under the CON program, and specific diagnostic or therapeutic equipment regardless of location is proposed for coverage. Applications to the program are currently considered on a first come first served basis, but will be grouped in the future in compliance with federal law. Under Michigan's debedding program, unneeded beds statewide are identified through the health planning process. A plan for reducing excess capacity is then formulated. A facility is required to develop and implement a planned reduction of excess beds identified in this plan for their facility in order to obtain a CON. Michigan has proposed in legislation a statewide cap on annual capital expenditures, a financial aid program for the closure and/or conversion of facilities, a consolidation into the HSA health plan of other categorical plans and state supported mergers of two or more private facilities. Michigan also has a shared regionalized services program.

Nurse specialty fields in Michigan are midwifery, practitioner and anaesthetist which are regulated by the Michigan Board of Nursing. Physician assistants are regulated by the Task Force on physician assistants. Physician supervision requirements are currently being drafted by two medical boards (M.D. and D.O.) so as to permit physicians to delegate specific functions to nurses and physician assistants. Such functions include the prescribing and dispensing of prescription drugs. Presently, physician assistants are permitted to prescribe drugs, except those classified as controlled substances, while nurses are permitted to administer drugs. Certification in the nurse specialty fields will begin after administrative rules have been adopted sometime in the latter part of 1980. In 1980, an estimated 250 PAs will be licensed for practice in the state.

In Michigan, coordination between licensing and certification and technical assistance programs for licensure of hospitals and nursing homes have been adopted. Safety code evaluations include examination for duplication of or inconsistency with other state codes or regulations, public hearings and an appeals process.

The State of Michigan has expanded their in-home service program to include senior day care and to provide services year round. In 1980, independent state funds for the elderly contributed $593,305 to home health, $620,427 to homemaker, $304,444 to day care, and $86,145 for transportation among others. Additional funds support larger joint state-federal efforts in these same areas.

Michigan provides extensive non-institutional funding for the mentally and developmentally disabled including $7.3 million in 1980 for family foster care, congregate living, and child care for mentally disabled and $15 million for the same services for the developmentally disabled. In addition, the state provided $1.775 million for day care and $21 million for aftercare for these population groups in FY 1980. Michigan supports county operated residential and day treatment facilities at 90% of net unreimbursed costs.

Beginning in 1978 the Department of Mental Health undertook development of community living facilities for alternative intermediate services for the mentally retarded. These consist of newly constructed specially designed homes for four to eight individuals which are constructed (or remodeled) using private capital but leased by the state and operated by nonprofit organizations under contract with the Department. They are operated as extensions of the developmental disabilities centers. Plans are under way to use state Housing Development Authority funds to supplement private sources where needed for construction of new facilities. The buildings are designed as residences and intended to fit into neighborhood multiple family dwelling zoning. As of March 1980, 27 homes were operational. Plans now anticipate about 200 homes and consideration is being given to developing similar units for mentally disabled children. All of these units are intended to meet standards for federal ICF/MR financing. Start-up costs and delays in certification processes have reduced federal revenues from ultimate 50% financing.

Finally, the state subsidizes family foster care and group homes for both disabled populations. Department of Mental Health sponsored homes are all licensed as family (foster) care homes or group homes. The Department currently contracts with these homes for basic care for those individuals without SSI benefits plus mental health programming services at $9 per day or at lower or higher rates depending upon the requirements of the individuals placed.

## MINNESOTA

While no one coordinates health care cost containment policy in the Governor's office, the Governor has announced an intention to appoint a study force to examine competition in the health care sector. State health and welfare programs are coordinated by a human services task force.

Minnesota's reporting and rate review program has been amended to allow hospitals with an expected increase in gross acute care charges less than an acceptable amount determined by the Commissioner of Health, an exemption from the review process.

Benefit packages, premium rates and medigap benefits offered by Blue Cross/Blue Shield and commercial carriers are subject to the approval of the commissioner of insurance. Cancer insurance offered by Blue Cross/Blue Shield and commercial carriers are also subject to the commissioner's approval. Health maintenance organization benefit packages, medigap benefits and the composition or appointment must be approved by the Commissioner of Health. Drug costs and HMO plans are required to be made available as public information in Minnesota.

Sanctions for violations of the state CON limits or other state guidelines are suspension or revocation of license, denial of licensure and injunctive relief. The CON program also covers outpatient hospital services and to a limited extent, specific diagnostic or therapeutic equipment. Applications to the program are considered on a first come first served basis. Minnesota has adopted in legislation a financial aid program for the closure and/or conversion of small hospitals to nursing homes.

Technical assistance programs for licensure of hospitals, nursing homes and rural health clinics have been adopted. Examination for duplication of and inconsistency with other state codes and regulations, as well as a public hearing and an appeals process for codes and regulations, are included in the evaluation mechanism of the building, fire and safety code.

Rules for the registration of physician assistants are currently pending. According to those rules, the State Board of Medical Examiners would administer the PA program. PAs would practice under supervision by telecommunications. Some authority would be granted to administer drugs; dispensing and prescribing is prohibited in the pending rules. FNPs are not licensed in the state.

The Minnesota Department of Health provides epidemiological consultation to local health agencies, physicians and communities pertaining to disease prevention, surveillance and control programs and epidemiological investigations. Extensive immunization, venereal disease and TB programs are conducted at the state level to prevent or control certain diseases. Chronic disease prevention occurs via smoking cessation program coordination efforts, hypertension program control coordination, and epidemiological investigations of environmental risk factors. Funds for both joint state-federal and independent state programs on communicable disease control expenditures rose from a total of $860,000 in 1978 to $1.1 million in 1980, for TB screening and control from $157,000 to $181,000 in 1980. Joint programs in venereal disease control received an annual average of $314,000, hypothyroid testing $72,000, and immunization $107,000. Nutrition education for children and pregnant women increased from $170,000 in 1979 to

$478,000 in 1980. Smoking cessation programs and health promotion and chronic disease epidemiology received $31,000 and $50,000, respectively, in state funds during 1980.

Efforts in non-institutional alternatives for the elderly focus on home health efforts. State funds in 1980 were $711,593 for these services. Some developmentally and mentally disabled persons benefit from these efforts as well.

The state has also made available $500,000 for special program grants to assist the elderly and physically disabled to reside in a family setting or home community.

In addition, equal matching shares from the state and counties provide SSI supplements to mentally retarded adults living in board homes, supervised apartments and foster care at $250 per month ($1.3 million each in 1979). Case management and support services received $693,000 for the same population in the same year.

# MISSISSIPPI

Mississippi's Certificate of Need law became effective July 1, 1979. The Licensure Division, by contract with OHHO, provides certification inspection for Medicaid-Medicare to ensure compliance with certificate to need limits on bed construction, capital expenditures or other state guidelines. Sanctions for violating the CON include jail sentence, fine, revocation of license, denial of reimbursement, denial of licensure, judicial injunction or nonlicensure of a specific service. In 1980 a fine was imposed and action on a jail sentence is pending for a violation which occurred in 1979. The CON program also covers outpatient hospital services when qualified as an ambulatory surgical center and specific diagnostic or therapeutic equipment which qualifies as major medical equipment ($150,000 and above). Competing proposals are grouped together for comparison before a selection is made.

The premium rates of Blue Cross/Blue Shield as well as the benefit packages, medigap benefits and cancer insurance of both Blue Cross/Blue Shield and commercial carriers require the insurance commissioner's approval.

To develop health manpower Mississippi's loan program provides assistance to students in return for a period of service after graduation. Between 1978 and 1981, an average of 46 students were enrolled in the program annually. Total assistance over this period was $1.5 million. In return for financial assistnace the recipients are required to practice primary care in communities in Mississippi with populations of 10,000 or less for five years. Failure to abide by the agreement results in a repayment of all monies at 6 percent interest per year plus $5,000 per year up to a maximum of $20,000. Students in this loan program are allowed residency programs in primary care.

Nursing specialties such as midwife and practitioner are regulated by the State Board of Nursing and supervised by written protocols. These health personnel have been granted limited authority to prescribe drugs. In FY 1980 an estimated 50 nurse midwives and 40 family nurse practitioners will be licensed for practice.

The state has coordinated licensure and certification surveys for hospitals and nursing homes. In addition, a technical assistance program for these same facilities has been adopted. Mississippi's evaluation mechanism for code requirements includes an examination for duplication of codes and inconsistencies.

State funds for health promotion and disease prevention were allocated for joint state-federal programs. The prenatal/postnatal program received $1.6 million in 1978, $1.9 million in 1979 and $2 million in 1980. TB screening and control received the next largest allocation of $1.3 million in 1978, $1.5 million in 1979 and $1.8 million in 1980. Venereal disease control received over $400,000 each year, early and periodic screening and diagnostic testing over $300,000 each year, hypertension screening over $270,000 and immunization over $400,000 each year.

Non-institutional aging services in the state include homemaker and chore services, congregate living services and transportation. Homemaker services funded by joint state-federal efforts dropped from $1,674,132 in FY 1979 to

$59,209 in 1980. Similarly, independent state program expenditures dropped. However, in FY 1980, the state began funding congregate living services ($1.04 million). Transportation increased.

Services for the developmentally disabled include day care, congregate living, foster care and transportation. Day care expenditures including Title XX programs in public schools were substantially reduced from 1978 to 1980. The state's independent expenditures for foster care, homemaker and transportation have increased as has the allocation to the joint state-federal congregate living effort. The state subsidizes six small group homes for this population group.

# MISSOURI

Health care cost containment policy for health, elderly and related programs is coordinated by an assistant in the Governor's office. Health and welfare programs are coordinated by SHCC and SHPDA. Missouri does not currently have nor is there a pending proposal for hospital rate-setting or budget review. A rate-setting/budget review system has been adopted for nursing home reimbursements from the state under Title XIX.

Benefit packages, medigap benefits and cancer insurance offered by Blue Cross/Blue Shield and commercial carriers are subject to the insurance commissioner's approval. State law specifies benefit coverage of newborn children, extension of age limits for certain handicapped dependents and for group policy coverage of alcoholism treatment.

To ensure compliance with Certificate of Need approved expenditures, Missouri requires periodic reports through the project. Facilities must also notify the review committee of changes in services, beds or licensure. Denial of state appropriations and licensure are sanctions available when violation of the CON occurs. The CON program also covers outpatient hospital services and clinic services, if the latter is part of a hospital. To handle application to the CON program, regulations are currently being developed and batching of the applications is under consideration. The Department of Mental Health has also purchased a nursing home.

The Division of Health in the Missouri Department of Social Services administers a scholarship program designed to encourage physicians to practice in rural areas. The state does not license PAs, FNPs, nurse midwives or nurse psychotherapists.

Licensing and certification of non-accredited hospitals are done at the same time. Missouri also provides a technical assistance program for licensure of hospitals. The evaluation of health care facilities for safety code compliance includes an examination for duplication of or inconsistency with other state codes or regulations as well as an appeals process.

The Bureau of Health Education in the Missouri Division of Health administers health education, health promotion, disease and accident prevention programs. Primarily, the bureau is concerned with improving citizens' lifestyles so as to reduce the risk of premature death, accidents and illness. The state funded programs for VD control, TB screening and control, hypothyroid and PKU testing, communicable disease control and hypertension screening among others as central prevention efforts.

In the area of alternatives to institutional care, Missouri operates state programs to provide home health, homemaker, day care, congregate living services, and transportation for the developmentally and mentally disabled. Over $2 million were used in the state to purchase boarding home services for these client groups in 1979. In addition, several counties in the state have passed property tax levies which provide for the construction and/or operation of community residencies for the mentally retarded/developmentally disabled.

# MONTANA

Health and welfare programs are coordinated by a special assistant to the Governor who is responsible for human services, budget and program planning. In regards to rate-setting/budget review, Montana does not have a state-run hospital rate review system. There has, however, been a voluntary rate review system in operation since 1971.

Montana's laws do not provide for prior approval of forms for Blue Cross/ Blue Shield, although the insurance division does have the right to disapprove for due cause. All forms used by other commercial carriers must receive prior approval. All carriers are subject to use of a disclosure statement in conjunction with the sale of policies supplemental to Medicare coverage. There is no enabling legislation for health maintenance organizations unless they fall into the non-profit category of health service organizations.

To monitor compliance with CON limitations on bed construction and capital expenditures Montana requires a report each six months and upon project completion. Sanctions which may be imposed for violations of the CON or other state guidelines include a fine, suspension or revocation of license, denial of licensure or an injunction. The CON also covers outpatient hospital services, and diagnostic or therapeutic equipment is proposed for coverage. Applications to the CON program are considered on a first come first served basis. Adopted on a demonstration basis are shared/regionalized services among facilities and the consolidation into the HSA health plan of other categorical health plans.

Montana does not have laws restricting advertising. Generally, fee advertising is not done although it is legally possible.

For hospitals and nursing homes, licensure, Medicare, and Medicaid surveys are conducted simultaneously. Certification standards have been adopted for licensure with the addition of several state requirements. Technical assistance programs for licensure of hospitals and nursing homes also have been implemented. Evaluation of such facilities for safety code requirements entails an examination for duplication of other state codes (health facilities are exempt from other building and fire codes) and regulations as well as cost-benefit analyses. Before licensing rules are adopted public hearings are held.

Nurse midwives are regulated by the Nursing Board and supervised by telecommunication and written protocols. They are granted emergency authority for prescribing and dispensing drugs and limited authority to administer drugs. In 1980, a total of 2 midwives were licensed.

In the area of alternatives to institutional care, the state independently funds congregate living services for the adult aged and disabled population. Funds for this program have doubled since FY 1978 from $300,000 to $600,000 in FY 1980. Joint state-federal expenditures provided homemaker and other chore services and case management and foster care for these client populations.

In January 1978, Montana signed a contract with NIMH to develop a community support system statewide to expand, increase and itensify services for the long-term mentally disabled living in the community. A major goal of this program is to prevent institutionalization and to reduce present state hospital census.

A model community support system was established at the South Central Montana Mental Health Center and this model is being replicated in the other four mental health centers in Montana.

In FY 1979, the five non-profit, private community mental health centers in Montana operated ten small group homes with the aid of state funding (50% of costs).

## NEBRASKA

Nebraska has a mechanism to monitor Certificate of Need approved bed construction and capital expenditures while the project is under construction. A requirement that a final report of capital expenditures be filed will be introduced in the next legislative session. Sanctions available to deal with violations of the CON or other state guidelines are a fine, suspension or revocation of license, and denial of reimbursement or licensure. The CON also covers outpatient hospital services, clinic services and specific diagnostic or therapeutic equipment. Applications to the program are considered on a first come first served basis. Nebraska has adopted a swing bed policy.

The premium rates of Blue Cross/Blue Shield and health maintenance organizations as well as the benefit packages offered by commercial insurers are subject to the insurance commissioner's approval. Medigap benefits and cancer insurance of all three carriers also require the commissioner's approval.

Nebraska does not have restrictions or requirements for advertising with one exception. HMOs must provide a statement describing their health plan to be filed in the Insurance Department and be available to the public.

While there is no mechanism to coordinate state health service needs as identified by the state health plan with decisions on financial assistance to medical school programs, medical students and teaching hospitals, a mechanism with the potential to perform this function exists. The Nebraska Commission on Rural Health Manpower is legislatively empowered to make recommendations on the above matters to the Governor, the Legislature and the University of Nebraska Medical Center. There is as yet no active coordination with the state health plan recommendations. Nebraska also has a loan program which requires one year of service in a medically underserved area for each year a loan was received in addition to repayment of the loan. Between Fiscal Years 1979 and 1981, enrollment has steadily increased from 10 to 30 students. Default provisions require repayment of the loan amount at an annual interest rate of 12.5 percent. Of the total assistance provided to residency programs in Fiscal Years 1978, 1979 and 1980, 21.5 percent, 22.2 percent and 22.3 percent were targeted, respectively, for community and family medicine and general practice programs each year. Physician assistants and registered nurses also receive assistance both directly and through state funds provided to colleges, universities and affiliated hospitals for their education.

Physician assistants are licensed to practice and are regulated by the State Board of Medical Examiners. Supervisory requirements include the physical presence of the physician and supervision by written protocols. The prescribing of drugs is prohibited. In 1980, an estimated 71 physician assistants will be licensed.

Nebraska has adopted some coordination between licensure, accreditation and certification surveys for hospitals and nursing homes. The safety code evaluation for health care facilities also includes a public hearing and an appeals process for codes and regulations. State statutes also require the State Fire Marshall to perform licensure inspections.

Several divisions in the Department of Health focus on health promotion and disease prevention. The Division of Health Education, which has special

programs in this area, including the federally funded Health Education/Risk Reduction program, is the coordinating mechanism in the Department. Average annual state allocations to joint state-federal programs for Fiscal Years 1978, 1979 and 1980 for venereal disease control were $69,000, $19,000 for immunization, and $61,000 for children and youth health projects. Independent state programs on TB screening and control averaged $210,000 and communicable disease control $48,000 over the same 3 years. Other joint programs received $1.7 million in 1978, $2.0 million in 1979 and $2.3 million in 1980 while independent state programs received over $400,000 each year.

Nebraska distributes state funds to regional programs operated under the reginal governing boards made up of County Supervisors from each county within a region. The funds totalling $4.2 million for the mentally disabled and $10.5 million for the developmentally disabled are targeted for day care (including health and social service programs). Part of those funds supported a half way house for adolescents and 120 small group homes for the developmentally disabled. Nebraska also participates in joint state-federal efforts for the elderly, developmentally and mentally disabled including case management, transportation and homemaker and other chore services.

The Nebraska Commission on Aging operates with state funding the "Grand Generation" program, a Nebraska Educational Television program providing information and referral services. In 1979, a bill was passed mandating cooperation in planning and service delivery for the elderly. In complying with that act a six-agency committee compiled statewide services to the elderly by the type of services, number of persons served and expenditures.

## NEVADA

The Nevada Office of Health Planning and Resources within the Department of Health and Human Services coordinates health care cost containment policy across health and health-related programs.

As a result of the Nevada Financial Disclosure Act, "all health and care facilities" are required to file annual financial statements with the insurance commissioner. (Facilities may be fined if they do not do so.) The commissioner is required to engage in or carry out analyses relating to health care costs in the state and other western states. A determination of the total financial needs of each facility, the resources available to meet those needs, and the effect of areawide and state health planning must be made by the commissioner. The report of the commissioner is available to the public. The statute also provides an exemption for facilities whose costs in providing the information would be materialy increased.

To monitor bed construction and capital expenditures no license will be issued or a change in licensure made by the state licensing agency without a letter of approval (CON) from the state health planning and development agency (SHPDA). Other sanctions which may be applied for violation of the CON are suspension or revocation of licensure. Clinic services for inpatients are also covered under the CON.

Only dental fee advertisements are restricted by statute in Nevada. In addition, pharmacies are required to advertise the availability of price information on drugs.

In an attempt to coordinate state health service needs with decisions on financial assistance to medical schools, the Greater Nevada HSA refers to the need for training physicians in primary care in the state health plan and indicates the role and importance of the medical school in the state's health care. Physician residency programs must be reviewed and approved by the legislature. Certain counties in Nevada have also adopted a loan program with payback provisions for medical students.

Nurse midwives and family nurse practitioners in Nevada are regulated by the Nursing Board. Physician assistants are regulated by the State Board of Medical Examiners and supervised through written protocols, telecommunications and by a physician on the premises. Some authority to dispense and administer drugs has been granted to physician assitants. Eighteen physician assistants are expected to be licensed in FY 1980.

Nevada has adopted measures to coordinate licensure, accreditation and certification surveys as well as technical assistance programs for both hospitals and nursing homes. Phase-in requirements have also been adopted for hospitals, and nursing homes and rural health clinics. The safety code requirements for health care facilities include an examination for both duplication of and inconsistency with other state codes and regulations. The evaluation also includes a public hearing and an appeals process for codes and regulations.

The State Health Division is the coordinating agency in conjunction with the HSA, on public health. Between 1978 and 1980, state expenditures for the

joint state-federal prevention programs examined rose from $625,915 to $1.33 million. In 1980, the largest program expenditures were for prenatal and post-natal care ($532,000), VD control ($245,797) and TB screening ($236,880).

In the area of alternatives to institutional care for the elderly, joint state-federal program efforts focused on home health, homemaker and other chore services through the Senior Companion Project, day care and support services. Funds were made available for home repair, legal services and maintenance and weatherization. The state also provided $682,000 in 1980 for congregate living services for the developmentally disabled. In 1979, fifteen small group homes and home residents received state subsidies.

The Governor's liaison for Health and Welfare is also the adviser on cost containment policy and health and welfare program budgets.

Benefit packages offered by Blue Cross/Blue Shield are subject to minimum standards. Premium rates on individual health insurance policies of commercial carriers, and the premium rates on Blue Cross/Blue Shield and health maintenance organization policies are subject to the insurance commissioner's approval. The composition of the board of trustees of Blue Cross/Blue Shield and HMOs, as well as medigap benefits and cancer insurance of Blue Cross/Blue Shield and commercial carriers, also are subject to the commissioner's approval.

To monitor compliance with Certificate of Need approved bed construction and capital expenditures, a mechanism for monitoring at specified intervals throughout project completion is proposed. Sanctions which have been adopted for violation of the CON limits or other state guidelines are a fine, suspension or revocation of licensure, denial of reimbursement or denial of licensure. The CON program also covers outpatient hospital services, clinic services and diagnostic or therapeutic equipment. Competing applications to the CON program are grouped together.

Regulations on prescription drug prices require pharmacies to post a list of the 200 most commonly prescribed prescription drugs and the current selling price in a conspicuous place in the pharmacy. Advertising of physician fees, dental care fees, psychiatric care fees and drugs are restricted by regulations.

Nurse midwives, nurse psychotherapists, and physician assistants are permitted to practice in New Hampshire. The nurse specialists are regulated by the State Board of Nursing, while the physician assistants are regulated by the State Board of Medical Examiners. Emergency authority to prescribe and dispense drugs has also been granted to nurse midwives and nurse psychotherapists. In Fiscal Year 1980, 8 nurse midwives, 22 nurse psychotherapists and 37 physician assistants will be licensed.

With federal funds, the state provides hypertension control and prevention, disease risk reduction and health promotion. Through a merger of state and federal funds a system is in place to provide nutritional information, dental disease prevention, child health assessment and the prevention of communicable diseases. Federal funds also permit prevention of hypothyroidism and PKU, both of which cause mental retardation. Annual state allocations to joint state-federal programs for prenatal and postnatal care averaged $242,000, TB screening and control averaged $122,000 and communicable disease received $52,000. Funds for venereal disease control increased from $19,000 in FY 1978 to $130,000 in FY 1980, from $72,000 to $100,000 for immunization and $426,000 to $702,000 for children and youth health projects.

In the area of alternatives to institutional care for the developmentally disabled population, state expenditures to date have focused on the provision of day care services ($500,000 in FY 1980) and case management. In addition, the state subsidizes 10 small group homes ($150,000 in FY 1979 for facility operation, $150,000 for renovation and construction) for this population group. The state also supports 2 homes ($120,000 in 1979) for the mentally disabled. Foster care for disabled and/or elderly clients was supported in 1980 with $1 million in state funds.

## NEW JERSEY

To monitor bed construction and capital expenditure the Certificate of Need program has implemented a health facilities construction and monitoring program. Sanctions which may be imposed for violation of the CON program include suspension, revocation or denial of licensure, denial of reimbursements or other grant programs. Outpatient hospital services and clinic services are also included in the CON program. While some applications to the CON program are grouped most are considered on a first come first served basis. The state has also adopted shared/regionalized services among facilities.

Public information is required on drug costs, HMO plans, other insurance plans, qualifications of physicians and non-physician personnel. Drug advertising regulations require the dissemination of drug cost information over the phone. Enrollees in HMO's are entitled to evidence of coverage and of the amount of payment the enrollee must prepay for health care services, while policyholders of other insurance plans must receive a certificate of insurance protection and benefits. Advertising of physician fees in a "dignified" manner is permitted. However, patient soliciting (i.e., discounts, special cures) is prohibited. Advertising of dental fees and prescription drugs is prohibited from referring to the quality of a drug or its official use or from selling at a retail price below the acquisition cost of the drug. HMOs are prohibited from unfair or misleading advertising.

Medigap and other benefits of individual health insurance policy offered by commercial carriers will be subject to New Jersey's Proposed Minimum Standards Regulation which specifies minimum benefits and rate standards. There is no comparable regulation for commercial group health insurance and no group health rate filing requirement. The benefits, rates, practices, and procedures of Blue Cross/Blue Shield are subject to review by the commissioner of insurance and are disapproved if found to be unfair, unjust or inequitable. Blue Cross/Blue Shield and commercial carriers are not permitted to offer cancer insurance.

Coordination of licensure, accreditation and certification surveys have been adopted for nursing homes as well as technical assistance programs for licensure of hospitals and nursing homes. Examination for duplication of and inconsistency with state codes and regulations as well as cost-benefit analyses are included in the evaluation mechanism of health care facilities safety code.

New Jersey's Technical Advisory Committee on Health Data, a state advisory group, identifies manpower as well as service needs. The Deparetment of Health provides manpower data through relicensure surveys which the Department of Higher Education uses to estimate total physician requirements as well as requirements specialty and geographic location. These projects serve as the basis for determining the level of state support for undergraduate medical education. These projections are also used to guide the funding activities of the Graduate Medical Education Program (GMEP), a special program designed to encourage expanasion and improvements in the quality of primary care residency programs in the state. The GMEP awards funds to public or private, non-profit hospitals in areas of greatest need to facilitate the development of innovations in residency training for the primary care specialties. New Jersey has also implemented a Physician-Dentist Loan Redemption Program designed to achieve results similar to a state health service corps or service conditional loan program by paying off a portion of the graduate's educational indebtedness. The

New Jersey program is structured such that students are under no prior commitment to serve in underserved areas. They apply to the program in their final year of medical or dental school. If accepted, they agree to serve for up to three years in an underserved area, institution or facility in the state. Upon completion of each year of service, the state will redeem a portion of the individual's educational indebtedness (principal and interest): 30% for the first year, 30% for the second year and 25% for the third year or a maximum of $30,000. The first participants will enter the program in July, 1980. It is expected that the program will include approximately 135 physicians and dentists when fully operational.

There are no laws in New Jersey permitting the practice of physician assistants, nurse practitioners, midwives, or nurse psychotherapists.

The State of New Jersey is using several innovative approaches to provide non-institutional alternatives to the state's elderly. These include tax measures which enable the elderly to remain in their own homes. Among them are:

1) Property tax reduction ($165) for those 65 and older;
2) Homestead rebate (all homeowners) but those 65 and older may apply for an additional $50 rebate;
3) Tenant credit (all tenants receive $65 credit after tax calculation, seniors may apply for an additional $35. Co-op apartments are eligible;
4) New Jersey gross income tax ($1,000 additional exemption for those 65 and older);
5) Pharmaceutical assistance (for low-income elderly who do not meet XIX criteria;
6) Reduced fares;
7) Utility bill credit.

With the exemption of transportation which received $5.77 million from the state in 1980 and $100,000 for congregate living services, the majority of state funds were for joint federal-state efforts.

New Jersey also provided $12.5 million in 1980 for transitional living services for the mentally disabled. Revised New Jersey rules and regulations require state funded mental providers in the community to provide non-institutional care.

New Jersey also provided independent state funds for services to the developmentally disabled including in 1980: 1) $8.3 million for congregate living services; 2) $4.4 million for day care; 3) $204,000 for foster care; and 4) $1.86 million for transportation. State contributions to joint federal-state efforts in the same year for the same services were: 1) $355,000, 2) $6.5 million, 3) 0, and 4) $513,000.

## NEW MEXICO

Health care cost containment policy in New Mexico is coordinated by the State Health Planning and Development Bureau within the Department of Health and Environment.

The benefit package, premium rates, medigap benefits and cancer insurance offered by Blue Cross/Blue Shield, health maintenance organizations and commercial carriers are all subject to approval by the insurance superintendent. Insurance carriers must file a copy of the form and premium rates with the insurance department and such a policy may only be implemented after a certain period of time unless the insurance superintendent gives written approval of the policy before the end of the time limit. The superintendent is required to notify the insurance company if the policy does not comply with legal requirements, if the benefits are unreasonable in relation to the premium being charged, or if the policy is otherwise misleading, unfair or deceptive. If the policy is found wanting, the superintendent must specify the reasons for such a finding, and it will thereafter be illegal for the company to use the insurance form in New Mexico.

Bed construction and capital expenditures authorized by the Certificate of Need program are monitored through progress reports required of the applicant, through a notice of construction by the Licensing Department, a notice of financing via bonds by the state bonding agency as well as a notice of completion by the fiscal intermediary. During fiscal year 1979 non-compliance was detected once by the monitoring mechanism. Sanctions which may be imposed on violators include a fine, suspension or revocation of license, denial of reimbursement or other grants of aid, denial of licensure or an injunction. The CON program also covers outpatient hospital services. Physician office services and diagnostic or therapeutic equipment regardless of location are both proposed for coverage. Applications to the CON program are considered on a first come first served basis, but are grouped if received within 45 days of each other. Adopted on a demonstration basis are consolidation of the HSA health planning process with planning activities for other categorical health programs into a single process, consolidation into the HSA health plan of other categorical health plans and the merger of public health care organizations with private organizations.

To aid the development of medical manpower, New Mexico has a loan program with payback provisions whereby a loan recipient receives state funds to finance his/her medical education. The recipient, at the end of his/her education, is encouraged to serve in a designated area suffering from a shortage of medical personnel. If the borrower chooses not to serve, the total loan amount plus 7% interest is established as a payout note providing for 24 equal monthly installments. Student enrollment in the program averaged 45 annually between Fiscal Years 1978 and 1981 with a total of 8 buying out.

Family nurse practitioners and physician assistants are allowed to practice in New Mexico and are regulated by the State Board of Nursing and the State Board of Medical Examiners, respectively. Supervision for both groups is by written protocols and nurse practitioners are granted some authority to prescribe drugs.

New Mexico has also adopted coordination between licensure, accreditation and certification surveys for hospitals and nursing homes. The state also includes in the safety code evaluation of health care facilities an examination for duplication of and inconsistency with other state codes and regulations, cost-benefit analyses, public hearings and an appeals process.

The Health Services Division of the Health and Environment Department is in the process of organizing a Health Promotion Bureau which will coordinate health promotion services in that Division. This Bureau should also improve coordination with other departmental divisions that are responsible for drug abuse, mental health, and occupational alcoholism and with other departments that provide services to elderly persons and children. The Health and Environment Department recently presented a statewide conference on disease prevention and health promotion. This resulted in the immediate development of an interdivisional colloquium whose purpose is to select and work through issues that require coordination to improve the quality of services for clients or enhance the skills and working environment of employees.

In 1979, the state provided $824,976 to support 22 small group homes for the developmentally disabled. In 1980, $545,700 were made available to assist foster parents who have children with developmental, mental or physical illness.

NEW YORK

Health care cost containment policy across health and health related programs is coordinated by a program associate in the Governor's office while the Office ofHealth Systems Management has the lead agency role. The Health Planning Commission coordinates state health and welfare programs. The Commission is chaired by the Special Assistant to the Governor for Health Affairs and each the New York state health and human services commissioner are members of he Commission. The Commission provides a mechanism where health and welfare issues are discussed and coordinated.

To assure compliance with the state Certificate of Need program, approved projects are monitored through construction and opening to assure cost control. Surveys of individual hospitals have revealed construction and service additions that are not in compliance with the CON. Sanctions which may be applied for violation of the CON are a fine, suspension and revocation of licensure, denial of reimbursement and other grants of aid, denial of licensure and court injunction. Other areas covered by the CON program are outpatient hospital services, clinic services and diagnostic or therapeutic equipment in a hospital. Major medical equipment in a physician's office that is related to inpatient care is proposed for coverage. Applications to the CON program are currently considered in a group. The CON program also provides the Commissioner of Health with the authority to decertify beds based on a lack of public need although this provision has never been used. Reimbursement penalties also encourage voluntary applications to decertify beds. In calender years 1978 and 1979, 880 and 856 beds were voluntarily decertified. The state has adopted in legislation a number of reimbursement incentive programs to encourage conversions, closures and shared or regionalized services among facilities. Adopted on a demonstration basis is a state wide cap on annual capital expenditures and state supported mergers of two or more facilities.

Public information regulations require that a hospital provides an explanation of bill to patients, that pharmacies post the prices of the 150 most commonly prescribed drugs, that employers with 25 or more employees offer an HMO option in the health benefit plan, that the by-laws of a facility contain the qualifications required of a physician to enable the physician to work in the facility and tht the by-laws provide procedures of physicians and specialists assistants working in the facility. The rules and by-laws are to be made public information upon request. Ancillary service costs and other insurance plans are also required to be made public information. New York state regulations restrict advertising of physician, dental and psychiatric care fees and non-physician practitioner fees. The law regards it as unprofessional conduct to advertise prices unless it is for "routine professional services" and unless the advertisement also states that there will be additional charges if in fact there are. This applies to physicians, physiotherapists, dentists, psychiatrists, nurses, et. al.

Cancer insurance policies are prohibited in the State of New York. The Commissioner of Insurance must approve the benefit packages, premium rates, and medigap benefits offered by Blue Cross/Blue Shield, health maintenance organizations and other commercial carriers. The composition of or appointment to the board of trustees of Blue Cross/Blue Shield and health maintenance organizations must also be approved.

New York state has no formal mechanism to coordinate state health service needs with decisions on financial assistance to health manpower development. However, the Commissioner of Education is a member of the Health Planning Commission and decision makers maintain close contact with the state health planning process. The state does, however, have a state health service corp, the Regents Physician Shortage Scholarship as well as a Supplemental Loan Program for Health Professions Students. The Regents program makes 60 awards each year up to a total of $240,000. Recipients of the award agree to practice 9 months for each annual scholarship award received, in an area of New York state designated as an area of physician shortage. Failure to serve requires repayment of the funds based upon the ratio of the number of months the recipient failed to serve to the number of months he/she was obligated to serve at 7 percent interest. Minimum monthly payments are $30 plus interest over a maximum period of 10 years. The Supplemental Loan Program for Health Professions Students have granted loans to 102, 1572, 7131 students in 1978, 1979 and 1980, respectively. In 1978 total loans amounted to $228,000, in 1979 $4.3 million and in 1980 $22.2 million. The state also provided $1.8 million, $1.7 million and $1.8 million in 1978, 1979 and 1980, respectively, which did not require repayment. Direct financial assistance from the state to medical school, teaching hospitals and affiliated institutions for the training of medical students and residents amounted to $12.7 million in 1978, $13.6 million in 1979 and $14.1 million in 1980. Additional funds to residency programs totaled $1.5 million in 1978, $1.7 million in 1979 and $2 million in 1980, all of which were specifically targeted on family practice residency.

Nurse midwives, family nurse practitioners, and nurse psychotherapists are listed as RNs. Physician assistants are registered as RPAs. For nurse midwives, the State Department of Health issues an "approval to practice." PAs are regulated by the State Board of Medical Examiners. Physician assumes supervising responsibility for both PAs and midwives. PAs have some prescribing authority. Nurse midwives are prohibited from prescribing drugs.

The state has adopted interchangeable state licensure, voluntary accreditation and certification standards for hospitals as well as simultaneous inspection of hospitals by state surveyors and the Joint Commission for the Accreditation of Hospitals. A one year trial of a technical assistnce program for hospitls, nursing homes and rural health clinics has been completed. New and amended standards/requirements are always phased in. The evaluation safety code requirements for health care facilities include an examination for duplication of and inconsistency with other state codes or regulations, cost benefit analyses, a public hearing and an appeals process.

In regards to health promotion and disease prevention, the Health Education Promotion Services concentrate on using the mass media to inform and motivate people about certain health behaviors, issues and services. Marketing techniques that have proven successful in other settings are being used and efforts are being made to utilize the film and print media in a manner not traditionally explored in public health. The Office also conducts research and demonstration projects designed to identify more effective ways of using the media to encourage people to adopt healthier lifestyles. Health promotion campaigns cover a wide range of issues ranging from prenatal care to venereal disease. In developing the programs the Office sets goals and objectives, identifies the target audience(s), assesses current knowledge, attitudes and behavior of this group as related to the health topic, and designs a mass media campaign utilizing the various media to accomplish the goals and objecties. Once implemented, the campaign is then evaluated.

State expenditures for children and youth health projects, including prenatal and postnatal care, rose from $40,000 in 1978 to $52,500 in 1980, from $400,000 to $515,000 for immunization and $150,000 to $180,000 for hypertension screening over the same period. During 1980, $380,158 was allocated to communicable disease control, $300,000 for teenage pregnancy, $271,000 for hypothyroid testing and $132,000 for venereal disease control. These allocations are state contributions to joint state-federal programs.

New York state has developed several innovative programs for the elderly including: 1) a program of state aid to localities to provide Community Services for the Elderly which involves the planning and implementation of community based service projects for the high risk, impaired elderly; 2) the Robert Wood Johnson Foundation has provided a grant to Erie County which will provide access to services for the elderly suffering from health problems. The program will be implemented through the Coordinated Care Management Corporation; 3) The National Long Term Care Channeling Demonstration grant will provide funds for the development of a state plan for long-term care as well as implementation of a demonstration program on screening, assessment and case management services for the functionally impaired. New York has also contributed approximately $4 million annually since FY 1978 to joint state-federal programs on home health care for the elderly and an annual average of $13.96 million since FY 1978 to joint state-federal programs for day care health and social services also for the elderly. In addition, independent state programs for home health care, again for the elderly, received $2.038 million in 1980, homemaker and chore services a total of $202,278, day care, health and social services $5.91 million and case management $638,444, all in 1980.

## NORTH CAROLINA

Although the North Carolina Certificate of Need program does not have a mechanism to monitor compliance with CON authorization of bed construction and capital expenditures, in the case of proven violations the state may impose sanctions including a fine, suspension or revocation of license, denial of licensure and injunctive relief. The CON program also covers outpatient hospital services, clinic services in a hospital or health care facility, physician office services and diagnostic or therapeutic equipment in a hospital or health care facility. Applications to the program are currently considered on a first come first served basis, but they are planning to group proposals in the future.

Benefit packages, medigap benefits and cancer insurance of Blue Cross/Blue Shield and commercial carriers must be filed with the state insurance department. Statutes require that each company licensed to sell life, accident and health insurance file the policy form for approval, plus the rates for the policy premium. The state does not approve or disapprove rates. However, if the rates or rate increase request appear to be excessive, the state will investigate. The policy forms submitted are reviewed to ensure compliance with the statutes or regulations.

A state health service corps has been implemented whereby medical students in medical and related studies may receive funds for their medical education in return for a period of service in a medically underserved area or facility. Enrollment of medical students alone between Fiscal Years 1978 and 1981 averaged 384 with 12 to 14 students buying out of program annually. Recipients of the loan from medical and related disciplines are allowed to practice in communities with populations not exceeding 10,000 in which there is a critical need for medical practitioners; in state owned mental, tuberculosis and rehabilitation facilities; mental health clinics and correctional or youth services facility sponsored by the community; state and local public health departments and non-profit community primary care programs; or primary care practice in a medically underserved urban or rural area not included in the previous categories. If a participant should become ineligible to continue participating in the program, cash repayment (principal plus interest at 7%) is due within 90 days of the recipient's ineligibility. Recipients in all disciplines approved for assistance under the state health service corps may choose to practice in any mental health facility excluding federal institutions. In 1980, SHSC expenditures were $600,000 for physicians, $20,000 for physician assistants, $5,000 for nurse practitioners, and $215,000 for registered nurses.

Nurse midwives, family nurse practitioners and physician assistants are permitted to practice in North Carolina. The nurse specialists are regulated by the State Board of Nursing and State Board of Medical Examiners while physician assistants are regulated only by the latter Board. All three groups are supervised by telecommunication and written protocols and all have been granted some authority to prescribe, dispense and administer drugs. In 1980 an estimated 7 nurse midwives, 70 family nurse practitioners and 70 physician assistants were licensed.

State owned health facilities are subject to North Carolina's public disclosure law. No other requirements for advertising exist. Prohibitions do exist on advertisements of medicine purporting to cure incurable diseases.

North Carolina has adopted coordination between licensure, accreditation and certification surveys for nursing homes as well as technical assistance programs for licensure and phase in requirements for both hospitals and nursing homes. There are no state licensure laws for rural health clinics but technical assistance is available. Included in the safety code requirements for health care facilities are an examination for duplication of and inconsistency with other state codes or regulations, cost-benefit analyses, public hearings and an appeals process.

In 1980, the state provided $141,391 to state programs and $840,139 to joint state-federal efforts to provide homemaker and other chore services to the elderly. In addition, the Division of Aging's Homemaker-Home Health Aide Project was designed to provide a coordinated in-home service system in the state. The goal of this project has been to fund new or expanded in-home service programs with respect to homemaker-home health aide services, either directly or by purchase of services. An expansion and development of this type of service, under a variety of organizational auspices, can be used not only to meet the needs of clients eligible under Medicare/Medicaid or Title XX in-service eligibility requirements, but also to meet the needs of older adults who may pay part or all of the costs of the service. With the $300,000 FY 1980 appropriation, ten agencies were funded which provide services to older adults in thirteen counties.

North Carolina has also provided extensive support for group homes for the emotionally disturbed, apartment living for mentally retarded and disabled adults, ICFMR group homes, respite care for the mentally retarded and foster care.

The Governor's assistant for Human Resources coordinates health care cost containment policy for health and health related programs. This same Council also coordinates state health and welfare programs. The Social Service Board Medicaid Program has adopted a rate setting/budget review program for nursing homes. On a yearly basis, the Social Services Board negotiates a contract for an individual rate for each level of care in each North Dakota Long Term Care (SNF and ICF) and Basic Care Facility.

The upcoming revisions to the Certificate of Need program include a proposal to adopt a mandatory quarterly reporting system to facilitate the monitoring of compliance with the CON program. Non-compliance with the CON renders the violators liable to sanctions such as a fine, revocation or denial of license, and injunctive relief. Outpatient hospital services are also covered by the CON program. Applications to the CON program are currently considered on a first come first served basis but the program is planning to group proposals in the future. North Dakota has also adopted a swing bed policy on a demonstration basis.

The benefit package, premium rates, medigap benefits and cancer insurance offered by Blue Cross/Blue Shield, health maintenance organizations and other commercial carriers are all subject to the approval of the Insurance Commissioner. However, Blue Cross/Blue Shield's rate approval is pro-forma since they are entitled by statute to a rate increase whenever their reserves reach a certain level.

Regulations in North Dakota require information on health maintenance organization's plans, other insurance plans, qualifications of physicians and non-physician personnel to be made available to the public. The advertising of dental care fees is restricted by regulations.

No allied health professionals are licensed or practice in the state.

Interchangeable state licensure and certification standards have been adopted for hospitals, nursing homes and rural health clinics. Technical assistance programs for licensure of hospitals and nursing homes have also been adopted. The safety code evaluation for health care facilities includes an examination for inconsistency with and duplication of other state codes or regulations as well as an appeals process.

Although there is no special system to coordinate health promotion and disease prevention the state has allocated funds for various preventive health programs. Joint state-federal senior meals on wheels and congregate services received total state funds of $377,000, $541,000 and $682,000 in fiscal years 1978, 1979 and 1980 respectively. Prenatal, postnatal and perinatal care received $300,000, $266,000 and $271,000, respectively, over the same period of time. Nutrition education for the elderly, children and pregnant women received an annual average of $42,583, increasing from $27,000 in fiscal year 1978 to an estimated $59,000 in fiscal year 1980. Children and youth health projects also increased from $244,000 in 1978 to over $282,000 in 1980. Some projects such as immunization and hypertension screening increased and then decreased: immunization funds have gone from $5,000 to $60,000 and back to $21,000; early and periodic screening and diagnostic testing went from $56,000 to $63,000

and then down to $59,000 over the same three year time period. Independent state programs which received funds include TB screening and control, communicable disease control and sudden infant death syndrome at an annual average of $62,000, $37,000 and $10,000, respectively.

North Dakota has a local and state matching mill levy which is controlled by local governments. Funds derived are used to develop local programs.

The operation of the Medicaid program (the welfare department is the designated single state agency), and the health department which licenses (by state law) hospitals, is handled by working agreements. There is a close relationship, as both departments have cabinet status in Ohio.

Compliance with the Certificate of Need program is monitored in several ways in Ohio including rules on follow-up requirements, the linkage to the CON of hospital registration and nursing home licensure, the surveillance of data from annual hospital registration and finally, on-site hospital surveys. Violations of the CON are liable to a jail sentence, fine, denial of reimbursement, denial of licensure and injunctive relief. The CON program also covers outpatient hospital services. At present the applications to the program are considered on a first come first served basis although the program is planning to group proposals in the future. The state has also adopted a swing bed policy.

In Ohio the benefit package and premium rates of health maintenance organizations are subject to the insurance commissioner's approval. In regard to Blue Cross and commercial carrier's benefit packages there are several mandated benefits which are required including continuation of coverage for certain handicapped dependents past the limiting age, mental health benefits to a minimum of $500, and alcoholism treatment to a minimum of $500 among others. While there are no group rate regulations, all individual policy rate increases for Blue Cross and commercial insurers are reviewed and the insurance regulations require premiums to be reasonable in relation to the benefits and require minimum loss ratios. The composition of or appointment to the Board of Trustees of Blue Cross also require approval. In Ohio, Blue Shield plans are commercial insurance companies and are regulated as such.

Ohio regulations require a pharmacy or pharmacist engaged in retail sales to disclose price information including the price charged, the proprietary name of the drug product, the generic name, strength, dosage and quantity. Health maintenance organizations are required to furnish subscribers with a list of available services and participating physicians. Information on the HMO's grievance procedure is also to be included in the annual statement. Other insurance plans such as Medical Care Corporations, Health Care Corporations and Dental Care Corporations are required to provide their subscribers, on an annual basis, with a description of the covered services and names and address of local participating providers. In regard to advertising restrictions, chiropractors, are prohibited by statute from advertising fees. However, administrative regulations governing chiropractic practice clearly contemplate fee advertisement as the regulations subject chiropractors to the same standards imposed upon physicians, podiatrists, psychiatrists, speech pathologists, optometrists, audiologists and sellers of pharmaceutical products. These practitioners are not restricted from advertising their fees but are prohibited from employing fraudulent or deceptive advertising. Dental fees may only be advertised in accordance with regulations.

In Ohio nurse midwives and physician assistants are licensed to practice and are regulated by the State Board of Medical Examiners. As to physician supervision requirements the degree of supervision for physician assistants depends upon the function being performed and the physician may not need to be

present. For nurse midwives, a physician is not required to be present but must be available should the delivery become complicated. Both nurse midwives and physician assistants are prohibited from prescribing, dispensing or adminstering drugs although they can carry out or relay a physician's orders for medication in accordance with state and federal drug laws.

At the Ohio Department of Health most prevention programs are located in the Bureau of Preventive Medicine. A liaison is maintained between this bureau and other bureaus which house additional prevention programs (e.g., Maternal and Child Health). The Bureau of Preventive Medicine has a number of advisory committees or councils appointed by the Governor and/or director of health which coordinate prevention activities with other state and private (e.g. voluntary) agencies or individuals. In fiscal year 1980 Ohio allocated $204,000 in state funds to a joint state-federal program on prenatal, postnatal and perinatal care, and $55,000 to hypothyroid testing. Communicable disease control received an annual average of $1.1 million, venereal disease control $227,000, and nutrition education for the elderly and children $49,000. The early and periodic screening and diagnostic program received over $847,000 in fiscal year 1978 and decreased to $768,000 in 1980 while immunization increased from $7,500 in both 1978 and 1979 to $219,000 in 1980. Independent state programs on TB screening and control received an annual average of $596,000 in each fiscal year.

In the area of alternatives to institutional care for the mentally disabled, the state supports 1) biological and nutritional research related to mental illness, 2) adult foster care for the mentally ill on a coordinated basis, and 3) extensive use of Title XX funds for day care and support services for the mentally disabled and developmentally disabled population. State investment in foster care for the mentally disabled was $1.4 million in 1980 and $21.3 million for the developmentally disabled. State allocations for home health services for DD clients equalled $1.9 million in the same year. Independent state expenditures for day care for the mentally disabled population were $4.2 million in FY 1980. In 1980, the Ohio Commission on Aging provided $1.3 million to joint state-federal efforts to provide home health services, $2.3 million in homemaker and other chore services, $1.2 million for day care, $.320 million in foster care, $.700 million in transportation and $.415 million for home delivery and congregate meals for the elderly population in the state.

## OKLAHOMA

Health care cost containment policy is coordinated by a senior administrative assistant in the Governor's office. The Governor's mini-cabinet and cabinet coordinate state health and welfare programs.

Current regulations in Oklahoma require that both forms and premium rates for Blue Cross/Blue Shield be filed with and approved by the Insurance Commissioner. However, the Oklahoma Senate has voted to remove, as of October 1, 1980, the rate approval requirement. The law also stipulates that directors of such corporations must include administrators or trustees of hospitals which have contracted with the corporation to render services, physicians and surgeons licensed in the state and members of the general public, exclusive of hospital representatives and physicians. Medigap benefits and cancer insurance offered by Blue Cross/Blue Shield will also, as of October 1, not require rate approval while the benefit package will continue to require such approval. Benefit packages, medigap benefits and cancer insurance sold as individual and group accident and health policies offered by commercial carriers are subject to the prior approval of the insurance commissioner. Health maintenance organizations are regulated by the Health Planning Commission which receives advice on fiscal responsibility and integrity of applicants for licenses from the Insurance Commission.

Bed construction and capital investment authorized by the Certificate of Need program is monitored by the Title XVIII and XIX intermediaries. Sanctions which may be imposed for violation of the CON or other state guidelines include a fine and denial of licensure. The CON program also covers outpatient hospital services and clinic services in a hospital. Applications to the CON program are currently considered on a first come first served basis.

The State Health Planning Commission is required by law to evaluate the effectiveness of publicly financed programs aimed at adequate supplies and distribution of health manpower. The state has also implemented a loan program with payback provisions (Physician Manpower Training Commission) in which an average of 61.5 students will have enrolled annually between Fiscal Years 1978 and 1981. Of the total 246 who will have enrolled during this period, a total of 12 are expected to buy out of the program. Students in the Rural Scholarship Program select a practice site after completion of graduate training and are required to practice one year at that site for each year a loan was received. Those enrolled in the Community Matching Scholarship Program select a site while still in medical or osteopathic college and must also serve one year for each year a loan is received. If the physician does not honor the contract, the penalty is a 100% increase of the total loan amount plus 10% interest to be repaid. Residency programs received $1.1 million, $1.3 million and $1.5 million in each of the three years. The majority of these funds were targeted to primary care residencies. The state also provided an annual average of $182,000 for the education of physician assistants and $1.5 million for the education of family nurse practitioners and registered nurses. These sums are also exclusive of library, physical plant, administration or other overhead expenses.

Nurse midwives, family nurse practitioners, nurse psychotherapists and physician assistants are allowed to practice in Oklahoma. The nurse specialists

are regulated by the State Board of Nursing and are supervised by written protocols. They have also been granted some authority to administer drugs.

Oklahoma has adopted technical assistance programs for licensure for hospitals and nursing homes.

To provide state coordination of health promotion and education between all relevant agencies the Health Education Council was created. The Oklahoma State Department of Health, through its statewide surveillance and county health departments, helps to coordinate efforts directed toward disease prevention. To this end the state has provided for joint state-federal programs an annual average of $575,000 for prenatal and postnatal care, $144,000 for venereal disease control, $309,000 for TB screening and control and $110,000 for immunization. Other joint programs that are receiving funds include communicable disease control and early and periodic screening and diagnostic testing program. Independent state programs for the detection of cervical cancer received $331,000 in 1978 and $340,000 in 1979. The joint cervical cancer program received $517,000 in 1980.

In 1980, the State of Oklahoma allocated $215,000, $604,814, $138,233, and $578,194 to provide home health, homemaker, day care and transportation services to the elderly, respectively.

## OREGON

With the exception of the state health planning function, health and welfare programs are within the Department of Human Resources. The Director of that department is responsible for internal coordination. The Director of the State Health Planning and Development Agency is expected to work with the Department of Human Resources on common concerns. An Assistant Director of the latter department is a Governor's appointee on the State Health Coordinating Council to further facilitate cooperation and input.

For the purposes of state reimbursement to facilities, Oregon has adopted a rate setting process for nursing homes and home health. The rates for home health are set through contracts which attempt to streamline and standardize rates. Ambulatory care is being considered for rate-setting in an attempt to standardize rates across providers. The rate-setting process for state reimbursements under Title XIX which has been adopted for hospitals has not been revised.

Benefit packages, medigap benefits and cancer insurance offered by Blue Cross/Blue Shield, health maintenance orgnizations and other commercial carriers require prior approval. Premium rates offered by these corporations do not require approval but the rates must be proper for the benefits provided. The insurance commissioner may reject the appointment of any officer or member of the board of directors or remove him/her from office for all three corporations.

To monitor Certificate of Need approval of bed construction and capital expenditure, the state has incorporated a monitoring mechanism, similar to federal guidelines, in its CON program. Sanctions which may be imposed in cases of violation include suspension and revocation of license, denial of licensure and injunctive relief. The CON program also covers outpatient hospitals services, clinic services in certain instances and diagnostic or therapeutic equipment in a licensed health care facility.

Hospital room charges and HMO plans are filed with the State Health Planning and Development Agency which makes the documents public records available for inspection. The application of a physician to practice in Oregon is also a public record.

The 1979 Oregon legislature created a Rural Medical Education Loan Program but provided no appropriation for its support. The future of the Rural Medical Education Committee, appointed by the Governor in March 1980, is currently under study and at this time has not been funded. Recipients would be required to practice in a medical shortage area for a period equal to the period covered by the loan but no less than two years. Borrowers who fail to graduate shall repay the loan plus 10% interest from the date the loan was granted. If the borrower graduates and is licensed, but does not practice in a medical shortage area as agreed, the borrower must repay the loan at 10% interest plus a penalty fee equal to 25% of the amount of the loan. The state also provided $11.3 million in 1978, $11.4 million in 1979 and $15.2 million in 1980 to medical schools, teaching hospitals and affiliated institutions for the education of medical students and residents. Residency programs received $4.4 million, $4.8 million and $5.3 million in the same years. Of the amount provided to residency

programs, $265,000, $290,000 and $319,000 were specifically targeted on community and family medicine and general practice programs in each of the three years.

Physician assistants are licensed to practice in Oregon and are regulated by the State Board of Medical Examiners. They are generally supervised by a physician on the premises but in medically disadvantaged areas by telecommunication. They have also been granted some authority to prescribe, dispense and administer drugs. In 1980 an estimated 16 physician assistants will be licensed.

Hospitals in Oregon can substitute JCAH certification for state licensure. Other types of coordination between licensure, accreditation and certification surveys, technical assistance programs for licensure and phase in requirements have also been adopted for hospitals and nursing homes in the state. Rural health clinics in Oregon are only certified. The safety code evaluation of health care facilities also includes an examination for duplication of and inconsistency with other state codes and regulations. A cost-benefit analysis, public hearing and appeals process have also been included.

The Oregon health promotion and disease prevention program is limited to early and periodic screening and diagnostic testing. The state allocated $827,000 in 1978, $980,000 in 1979 and $900,000 in 1980 to a joint state-federal program for this purpose.

To promote independent living for the elderly, the State of Oregon allocated $2 million in 1980 for the provision of homemaker and other chore services. Federal and other resources in excess of $1 million added to the state effort. Oregon also supports 23 small group homes for the mentally disabled and 32 for the developmentally disabled population. In 1979, state subsidies for these homes exceeded $1.1 million.

## PENNSYLVANIA

To contain health care cost the Governor has created the Task Force on Controlling Health Care Costs which is chaired by the state insurance commissioner.

The Pennsylvania Department of Health expects to take a leadership role in developing a workable hospital prospective reimbursement program at the state level. They are in the very early stages of researching hospital cost containment legislation of other states to ascertain what may be workable. They are convinced that in order for a prospective hospital reimbursement program to be developed and implemented a broad coalition of business, labor, government and providers must be behind such an effort.

Pennsylvania's Certificate of Need program is to have taken effect September 1, 1980. To monitor compliance with CON-approved bed construction and capital expenditures periodic progress reports are required. The certificate will expire unless the project has been substantially implemented. Sanctions available to deal with violations of the CON or other state guidelines are a fine, revocation of licensure and denial of licensure. The CON program also covers outpatient hospital services, clinic services, physician's office services and diagnostic or therapeutic equipment. New health services offered in or through a health care facility or HMO are covered. A service is offered in or through a health care facility or HMO if the service is offered or made available on a regular basis to inpatients or outpatients of a health care facility or HMO. Applications to the CON program are grouped and examined during one of the six review cycles each year, however, proposed amendments to the CON statutes will reduce it to at least three review cycles per year.

The approval of the insurance commissioner is required for all benefit packages, premium rates, the composition of or appointment to the board of trustees, medigap benefits and cancer insurance offered by Blue Cross/Blue Shield, health maintenance organizations and other commercial carriers.

The state is planning to adopt interchangeable state licensure, voluntary accreditation and certification standards as well as simultaneous inspection by state surveyors and the Joint Commission for the Accreditation of Hospitals for nursing homes and hospitals. Other type of coordination between licensure, accreditation and certification surveys as well as technical assistance programs for licensure have already been adopted for nursing homes and hospitals.

Pennsylvania has adopted regulations requiring certain information pertinent to health care costs be made available to the public. A current schedule of hospital rates and charges are required by law to be maintained and made available upon request to those who use the services. HMO's must also file with the commissioner an annual report of financial activity of the preceding year and its financial condition at the close of the year. Other insurance plans must furnish to policy holders an individual certificate summarizing the essential features of the insurance coverage. Physicians who have complied with the rules and regulations of the state shall receive a licensing certificate which is recorded and open to public record. The qualifications of non-physician personnel are also a matter of public record. Restrictions on advertising have been placed on dental care fees, non-physician practitioner fees and drugs.

To meet state health service needs as identified in the state health plan Pennsylvania appropriates money through a 10% capitation grant to its medical schools.

The Division of Health Education in the Bureau of Public Health Consultative Services develops plans that place particular emphasis on health promotion. Program coordination is provided between the Division of Health Education and those programs that deal with disease prevention and in developing program plans and evaluative review. Linkages are established between the Bureau of Epidemiology and Disease Prevention and the Bureau of Public Health Consultative Services. The Divisions of Nutrition, Health Education and Social Work are each aimed at promoting health services and disease prevention through self education approaches. Health behavior and/or change in lifestyles are considered in all aspects of planning; instructions provided for individuals in community health problem solving and decision-making.

Towards this goal the state allocated state funds to numerous joint state-federal programs aimed at health promotion and disease prevention. Nutrition education for children and pregnant women received over $280,000 in 1978, $442,000 in 1979 and $1.1 million in 1980. Additional independent state program for nutrition education not only for children and pregnant women but also for the elderly received $246,000 in 1978, $246,000 in 1979, and $308,000 in 1980. Joint programs on prenatal and postnatal care received $2.7 million in 1978, $2.9 million in 1979 and $3.3 million in 1980 while independent state programs received $3.4 million, $3.7 million and $3.6 million over the same period. The state also provided an annual average of $357,000 for its own program on perinatal care again over the same three years. Substantial state funds also went to the joint program on children and youth health projects which received $11.4 million, $21 million and $20.5 million in 1978, 1979 and 1980, respectively. Other joint programs on venereal disease control, TB screening and control and hypertension screening received an annual average of $268,000, $943,000 and $748,000, respectively. Funds were and are also being provided for other programs such as cervical cancer detection, communicable disease control, immunization and teenage pregnancy.

Pennsylvania has developed a domiciliary care program for the elderly in which persons over 18 years of age can live in a protected environment in the community. Clients of the domiciliary program are unable to live independently due to age, physical and mental impairement or their economic situation but yet do not require care 24 hours. The domiciliary program places residents in family like homes in which room and board are provided in addition to personal care services. The funding for independent state congregate living services for the elderly rose from $115,103 in 1978 to $243,411 in 1980 and state contributions to joint state-federal efforts from $551,593 to $924,344. Expenditures for homemaker and chore services rose from $3 million in 1978 to$5.19 million in 1980 from the state and from $9.69 million to $11.13 million in 1980 as the state match to joint efforts. State foster care funds declined from $394,324 in 1978 to $390,090 in 1980 for state-federal programs while independent state funds rose from $118,372 to $147,612 over the same period. Expenditures increased for other alternative service programs such as day care health and social services from $179,046 to $217,487 for state-federal programs and $5.58 million to $9.6 million for independent state funds; for case management from $1.3 million to $3.8 million for state-federal funds and $165,576 to $693,998 for state programs and for transportation services from $2.98 million to $6.22 million for joint funds and from $355,616 to $1.05 million for state funds. A total of 451 foster homes and 768 domiciliary care

homes, all under 16 beds are currently in operation for the elderly.

The state has also established residential living programs for the mentally disabled costing $5.4 million in 1980 including state subsidies to 34 small group homes. Independent state day care health and social services for the mentally disabled, including vocational rehabilitation, cost $12.2 million in 1980. Personal Care Boarding Home regulations were recently finalized, applications for licensure are now being accepted.

State programs for the developmentally disabled in 1980 include $52 million for congregate living services (supporting more than 1000 small group homes), $480,000 for home health and homemaker services and $2.2 million for transportation.

## RHODE ISLAND

To coordinate health care containment policy the Governor's Policy Office has an aide to the Governor for Human Services.

To monitor compliance with CON authorized bed construction and capital expenditures the Rhode Island CON regulations require summary progress reports detailing costs incurred at six month intervals plus additional requirements for cost overruns and changes in project scope. Monitoring is accomplished through coordination established with third-party reimbursement agencies. Noncompliance was detected once in FY 1978 and once again in FY 1979. Sanctions available to deal with violations include a fine, suspension, revocation, and denial of license, denial of reimbursement and denial of other grants-in-aid. The CON program also covers outpatient hospital services and diagnostic or therapeutic equipment. Clinic services are proposed for coverage under the CON. Applications to the CON program are currently considered on a first come first served basis but plans are being made to group such proposals in the future in compliance with new federal law.

A benefit package offered by Blue Cross/Blue Shield, health maintenance organizations and other commercial carriers that meet the requirement of qualified plan as specified by Rhode Island regulations, may be certified by the director of insurance. However, insurers are not now required to submit plans for review. A new law requires inclusion of alcohol rehabilitative benefits, and benefits will have to be reviewed to enforce this requirement. Medigap benefits and cancer insurance offered by all three insurers are reviewed to ensure compliance with standards provisions, law and regulations and with other requirements which deal principally with the basic rights of the insured and with adequate disclosure of certain policy provisions. Premium rates of all three carriers are subject to approval.

Under the health care facility licensing law, hospitals, skilled nursing facilities, intermediate care facilities, health maintenance organizations, renal dialysis centers and surgicenters must provide uniform reports relative to costs and changes for health care facility services. Regulations also require pharmacies to post a list of the 10 most commonly prescribed drugs and their selling price in a conspicuous place in the pharmacy and to provide upon request from a customer with a prescription information on the current selling price. Advertising of controlled substances is restricted by authority of the general laws and more specifically by the Division of Drug Control.

Coordination between licensure, accreditation and certification surveys as well as a technical assistance program for licensure has been adopted for nursing homes. Included in the safety code evaluation for health care facilities is an appeals process for codes and regulations.

Nurse midwives, family nurse practitioners, nurse psychotherapists and physician assistants are allowed to practice in Rhode Island. The State Board of Nursing regulates practitioners and nurse psychotherapists. The Physician Assistants' Examiner Board regulates physician assistants and another state agency regulates nurse midwives. The dispensing and prescribing of drugs by nurse practitioners and nurse psychotherapists is prohibited while nurse midwives are not only prohibited from dispensing and prescribing but also from administering drugs. Physician assistants are prohibited from prescribing

drugs. No physician assistants have yet been licensed in Rhode Island while 7 nurse midwives, 58 nurse practitioners and 20 nurse psychotherapists will be licensed in 1980.

Within the Rhode Island Department of Health, the Office of Health Promotion coordinates health promotion activities and the Office of the Association Director for Preventive Medicine coordinates disease prevention activities. To carry out these activities Rhode Island allocated state funds to several joint state-federal programs. From 1978 to 1980 prenatal and postnatal care received over $260,000 each year, perinatal care rose from $15,000 in 1978 to $25,000 in 1980, TB screening and control received over $158,000, each communicable disease control over $133,000, nutrition education over $50,000, immunization over $104,000, hypertension screening over $35,000 and children and youth health project over $69,000.

The Rhode Island Department of Social and Rehabilitative Services provides a series of services to the elderly and others, such as homemaker services, health related services, self-support services for the handicapped adults and housing services, so as to achieve or maintain self sufficiency. Rhode Island has also implemented several other programs to aid the non-institutionalized including the Clearinghouse Project between the Department of Elderly Affairs, Rhode Island Hospital and the Department of Social and Rehabilitative Services, a pilot program for in-home ongoing psychotherapy through Providence Community Mental Health Center and finally, ongoing consultation and education project for direct service aides through Washington County Mental Health Center. The Wood River Project, a joint state-federal home health service program, received $104,425 in 1979 and $141,922 in 1980 in state funds. Other home health services for the developmentally disabled received $8,000 in state funds in 1980. Homemaker and other chore services for the elderly also received $250,000 in 1980 while $210,000 ws allocated for day care health and social services. Transportation, a very important concern of the elderly, received $1.1 million from the state in 1980.

Independent state programs on congregate living services for the mentally disabled and developmentally disabled received $631,679 and $652,284, respectively, in 1980. State programs providing day care health and social services for the mentally disabled and developmentally disabled received $1.7 million and $3.4 million, respectively, in 1980. Ancillary services such as case management for the mentally disabled received $1.6 million in 1980 and transportation for the developmentally disabled received $152,855 also in 1980. These are state allocations for independent state programs.

Rhode Island has also established 4 small group homes, under 16 beds, for the mentally disabled and 1 for the elderly, all of which are owned by the state. For the developmentally disabled, 24 homes have been established, 19 of which are owned by the state. State loans or direct assistance to the homes for the mentally disabled totals $1.3 million, which represents the cost of 4 completed homes and 2 under construction. A total of $4 million in state loans or assistance was provided for the homes for the developmentally disabled.

## SOUTH CAROLINA

The Division of Health and Human Services has a health planning and research unit to review and coordinate policies to minimize health care cost increases. Most of the research is for in-house use for discussions and policy development. State health and welfare programs are coordinated by the Human Resource Coordinating Council. The Council is a voluntary consortium of state level health, habilitation and social services agencies established in 1975. Membership is composed of agency chief executives and governing board chairpersons. The Council solicits a close liaison with the Governor's office.

Benefit packages, premium rates for individual insurance, medigap benefits and cancer insurance offered by Blue Cross/Blue Shield, health maintenance organizations and commercial carriers all require the approval of the state insurance commissioner. Policies cannot be issued in South Carolina unless they meet the minimum standard requirement prescribed by the state, and the commissioner may disapprove or withdraw approval of field forms of policies if he determines that the premium charged is unreasonable in terms of the benefits provided.

To monitor bed construction a Certificate of Need is required prior to the licensing of additional beds. Sanctions which may be imposed for violation of the CON or other state guidelines include a fine, suspension and revocation of license, denial of reimbursement and denial of licensure. The CON program also covers outpatient hospital services and clinic services and proposes to cover diagnostic or therapeutic equipment. The program is also planning to group applications to the CON. Included in the CON statute is a provision for delicensing beds not projected as needed in the plan.

Regulations in South Carolina allow pharmacies to advertise retail drug costs but there is no requirement that they do so. The Medical Examiner's Board publishes a directory each year with information concerning the degree, school attended, birth data and place of physicians, osteopaths and physician assistants. This information is released to the public but there is no requirement that it be so released. The Board of Dentistry prescribes certain guidelines for advertising dental fees.

Technical assistance programs for licensure have been adopted for hospitals and nursing homes as well as phase-in requirements. Included in the Safety code evaluation for health care facilities is an examination for inconsistency with other regulations, a public hearing and an appeals process for codes and regulations.

A mechanism to coordinate state health service needs as identified in the state health plan with financial assistance to medical school programs, medical students and to teaching hospitals for residency programs has been discussed. South Carolina has implemented a loan program with payback provisions to enhance the development of medical manpower in the state. Between Fiscal Years 1978 and 1981 an estimated 50 persons have enrolled in the program. If an enrollee leaves the program for justifiable cause, approved by the Board of the Department of Health and Environmental Control, the enrollee must repay the principal at 7 percent interest compounded semi-annually. For leaving the program without justifiable cause, the enrollee must repay 3 times the principal plus 7 percent

interest compounded semi-annually. Medical student programs received $16.9 million for 1978, $20.4 million in 1979, and $24.6 million in 1980; residency programs received $13.3 million, $13.9 million and $15.0 million during the same period of time. Of the sum provided residency programs, 37.1% in 1978, 37.3% in 1979 and 37.5% in 1980 were specifically targeted on primary care residency programs including community and family medicine and general practice. Over the same three-year period, the state also provided $484,000 for the education of family nurse practitioners and $15.1 million for the education of registered nurses.

Nurse midwives, family nurse practitioners, nurse psychotherapists and physician assistants are all licensed for practice in South Carolina. The nurse specialists are licensed as registered nurses and are regulated by the State Board of Nursing. Physician assistants are regulated by the State Board of Medical Examiners. All three groups of nurse specialists are supervised by written protocols while physician assistants are supervised by the physician on premises, by telecommunication and/or by written protocols. Some authority to prescribe, dispense and administer drugs have been granted to the nurse specialists while physician assistants have limited authority only to administer drugs. In 1980, an estimated 21 nurse midwives, 49 family nurse practitioners, 14 nurse psychotherapists, and 180 PAs were licensed. Several other specialized nurse practitioner categories have been established in the state including School NP, Pediatric NP, Occupational Health NP, Nurse Anesthetist, Family Planning, etc. A total of 131 individuals are licensed for specialist nurse activities.

The South Carolina Department of Health and Environmental Control is charged with investigating the causes of disease in the state and the means of prevention, disseminating this information and conducting statewide programs on health promotion and disease prevention. Similar programs are conducted by the Department of Mental Health, the Commission on Alcohol and Drug Abuse and all three departments cooperate with the Department of Social Services and the Commission on Aging. The State Health Planning and Development Agency along with the Office of the Governor coordinates state efforts. Joint state-federal programs on prenatal, postnatal and perinatal care and teenage pregnancy received $9.4 million between 1978 and 1980. TB screening and control received $10.9 million and children and youth health projects received $6.7 million over the same three years. In each of the three years venereal disease control received over $418,000, cervical cancer detection $250,000, communicable disease control over $100,000, immunization over $411,000, PKU testing over $66,000 and hypertension screening over $100,000. The Institutional Avoidance (Court Screening) program for mentally disabled clients began in FY 1977-78 at one CMHC in South Carolina. This program is now in place at eight of the sixteen centers in South Carolina with a total budget of approximately $1.4 million. The primary goal of the program is to minimize the number of patients being treated at the central state psychiatric hospitals. In addition to joint federal-state efforts, the state also funds independent programs for developmentally disabled adults. In 1980, these programs provided home health services ($14,126) and day care and social services ($2.2 million).

The state of South Carolina has also received five-year funding from the Robert Wood Johnson Foundation for the establishment of a central coordinating unit to provide services for approximately 3,750 disabled elderly in two state counties. Each disabled person will have a comprehensive assessment of need followed by a plan to meet these needs. The plan will be administered by a

social or health agency with appropriate follow-up to assure timely response and quality care.

Fourteen health and social services agencies have agreed to establish a coordinating unit to ensure that each disabled elderly individual receives help to maintain maximum independence. Those family members who provide care will be educated and counseled by a staff person from the central coordinating unit.

## SOUTH DAKOTA

Health care cost containment policy is coordinated by the State Planning Bureau, a staff agency of the Governor charged with the coordination of state policy. The Departments of Health and Social Services, responsible for health and welfare programs are part of the Governor's Human Resources Cabinet Subgroup. This Cabinet Subgroup is a forum for discussion and a mechanism for the solution of shared problems.

Premium rates, medigap benefits and cancer insurance offered by Blue Cross /Blue Shield, health maintenance organizations and other commercial carriers all require the approval of the state insurance commissioner.

A monitoring process to see if cost overruns are probable events has been adopted by South Dakota in an effort to ensure compliance with the state Certificate of Need program. Sanctions which may be imposed in cases of CON violation are a revocation of license and denial of licensure. Outpatient hospital services (ambulatory surgical centers) and specific diagnostic or therapeutic equipment in an institutional setting are also covered by the CON program. Applications to the program are currently considered on a first come first served basis.

The posting of prescription drug prices in a pharmacy has been authorized by the state and a refusal by a pharmacist to quote the price of a prescription drug is considered a misdemeanor. Every health maintenance organization is required to file an annual report containing a financial statement and other relevant information. All applications, reports and filings of the HMO are considered public documents.

Physician assistants are licensed to practice in South Dakota under the supervision of a physician either on the premises, by phone or by radio. They may prescribe medication for symptoms and temporary pain relief. The State Board of Medical and Osteopathic Examiners regulate physician assistants. Nurse practitioners and nurse midwives are also licensed to practice and are regulated by the State Board of Nursing. A nurse practitioner may prescribe medication for the treatment of causative factors and symptoms, while nurse midwives may prescribe appropriate medications during the antipartal, intrapartal and postpartal period. Nurse practitioners and nurse midwives may practice only under the supervision of a licensed physician responsible for the medical care of the patient. Supervision may be by direct contact and/or via telephone or radio.

Total interchange between licensing and certification, excluding the Joint Commission for the Accreditation of Hospitals, has been adopted for hospitals. Complete interchange between licensing, accreditation, and certification for nursing homes that are Medicaid providers has also been adopted. Other types of coordination include the simultaneous survey of hospitals with attached nursing homes, and coordination for Medicare purposes with the State Board of Medical Examiners as to the qualification and function to be allowed physician extenders serving rural health clinics. Technical assistance and orientation to licensing regulations are also given to personnel of new health care facilities or a new administration of such a facility, and to rural health clinics that wish to become providers for Medicare as well as those already certified. A phase-in

period has been allowed for hospitals and nursing homes as state licensure requirements change. The evaluation of health care facilities for safety code requirements includes an examination for duplication of and inconsistency with other state codes and regulations in addition to cost benefit analyses, a public hearing and an appeals process for codes and regulations.

A pilot Health Education program will be implemented during fiscal year 1981. The Division of Elementary and Secondary Education in the Department of Education and Cultural Affairs and the State Department of Health have developed a draft Health Education Curriculum. The Division will work with the State Health Coordinating Councils Health Promotion and Detection Task Force to implement this curriculum and complete a proposal for a Health Education Coordinator. Other independent state funded prevention programs focused on occupational alcoholism and communicable disese control.

The State of South Dakota currently emphasizes adult foster care as an alternative to institutional care for the elderly. This foster care program provided $65,307 and $94,145 in subsidies in 1978 and 1979 respectively. The program experienced a dramatic increase in FY 1980 to $571,993.

# TENNESSEE

State health and welfare programs are coordinated by the State Planning Office which reviews fiscal overlap. An interdepartmental committee chaired by the Governor's office also discusses related policy matters on a weekly basis.

There is currently no hospital rate-setting or budget review program or proposal for such a program in Tennessee. Premium rates of Blue Cross/Blue Shield as well as benefit packages, medigap benefits and cancer insurance for both Blue Cross/Blue Shield and all other commercial carriers must be filed with the Commissioner of Insurance for approval. Rate approval for Blue Cross is based on the resonableness of premium charges to benefits provided. Rules for rate approval of commercial carriers are currently pending. The benefit package, premium rates and composition of or appointment to the board of trustees for health maintenance organizations must be filed with the insurance department but the commissioner's approval is not necessary.

Progress reviews are required based on established timetables to monitor construction authorized by the Certificate of Need program. Denial of reimbursement and/or of other grants-in-aid and denial of licensure are sanctions available to deal with violations of the Certificate of Need. Clinic services, certain outpatient hospital services, and diagnostic or therapeutic equipment, regardless of location, are also covered by the CON program.

Health maintenance organization's plans, other insurance plans, and the qualifications of physician and non-physician personnel are required to be filed and available to the public in order to obtain a license to operate. Restrictions on the advertisement of physician fees, dental care fees, psychiatric care fees, nonphysician practitioner fees and drugs do exist in the state.

Tennessee's loan program with payback provisions for medical personnel was discontinued in 1979-80. However, the state regulates the number of residents in family practice in state-supported schools. Further, all of state funds provided to residency programs were targeted for family practice residencies, totalling $2.4 million in 1978, $3.0 million in 1979 and $3.1 million in 1980. In 1978 and 1980 the state also provided $59,000 and $40,000 respectively to registered nurses which required a payback in services. Finally, the state provided $11.8 million in 1978, $13.2 million in 1979 and $14.8 million in 1980 to the medical student program.

Physician assistants are allowed to practice in the state and are regulated by the State Board of Medical Examiners. Supervision is by written protocols and they have been granted some authority to prescribe, dispense and administer drugs. New regulations pertaining to nurse practitioners have recently been passed and the state is in the process of developing rules for nurse practitioners and prescription writing.

For both hospitals and nursing homes the certification survey is accepted for licensure. Technical assistance for construction plans review is also provided for the same types of facilities. An examination for duplication of inconsistency with other state regulations, in addition to a public hearing and an appeals process, are all included in the safety code evaluation of health care facilities.

The Tennessee Commission on Aging oversees two innovative program efforts to increase the availability and coordination of non-institutional services for the elderly. The Project Access program in the First Tennessee-Virginia Development District for the chronically ill aged, funded by the Robert Wood Johnson Foundation has these goals:

1) to establish a policy council consisting of all major service providers;
2) to assess the physical and psycho-social needs of persons over 65;
3) to implement a client tracking system;
4) to develop an analysis of the board range of intervention modes utilized in meeting the needs of Project Access clients;
5) to optimize the use of currently available resources to serve a 15% increase of persons 65+ with multiple needs;
6) to develop a mechanism to serve clients denied services because of eligibility criteria; and
7) to strengthen the natural support system.

A second program, Project Life, encourages deinstitutionalization in the Memphis Delta Development District and is funded as a model project by the Administration on Aging.

Joint federal and state expenditures provided $3.2 million in support for congregate living services for the developmentally disabled population in FY 1980. Congregate living service expenditures subsidized 110 small group homes in the state. The Tennessee Mental Health and Mental Retardation agency is also participating in the following programs oriented toward non-institutional care: 1) a HUD sponsored project for replacement and construction of new group homes for the mentally retarded; 2) HUD/HHS Demonstration Program for the Chronically Mentally Ill; and 3) enactment of licensure standards (life safety and programmatically) and Department's monitoring of community programs (quality assurance). Plans are also underway to develop community support programs for residents discharged from developmental centers and that serves persons with a dual diagnosis of MR and emotional disorder.

Finally, Tennessee is trying to combine the Medicaid ICF/MR "15 bed or less" funds with HUD Section 8 funds to develop solid funding base for community mental retardation services that provide the following:

1) Physical facilities, that fit the needs of this special population (HUD)
2) Adequate funding to provide quality program services
3) Ancillary services that fit the needs of the clients
4) Clients services in an atmosphere of "normalization" rather than a medical environment

A State Agency Management Effectiveness Council and its subcommittee meets quarterly to discuss management goals and other common problems.

Sanctions which may be imposed for violation of the state Certificate of Need program or other state guidelines are a fine, suspension or revocation of licensure, denial of reimbursement and/or other grants of aid, denial of licensure, and forfeiture of the Certificate of Need. The CON program also covers outpatient hospital services and clinic services. Applications to the CON are currently grouped together for consideration. The state has also adopted on a demonstration basis swing beds and shared or regionalized services among facilities.

The state insurance commissioner's approval is required for benefit packages, the composition of or appointment to the board of trustees, medigap benefits and cancer insurance offered by Blue Cross/Blue Shield, health maintenance organizations and other commercial carriers. Premium rates offered by the latter two carriers are also subject to the commissioner's approval.

The State of Texas provided over $1 million in tuition and loan support to individuals enrolled in medical schools within the state in FY 1980 and FY 1981. In addition, the state will provide nursing students with $52,000 in tuition and loan support in 1981. The state also supports individuals enrolled in health sciences programs including physician assistants.

Physician assistants are licensed to practice in Texas under the auspices of the State Board of Medical Examiners. They are supervised by a physician who is present as the assistant engages in his work or a physician who is otherwise on the premises. Physician assistants are prohibited from prescribing or dispensing drugs. In 1980 an estimated 150 physician assistants will be licensed.

For hospitals and nursing homes coordination between licensure, accreditation and certification surveys have been adopted. Technical assistance programs for licensure and a phase in of requirements are offered. Included in the safety code evaluation for health care facilities are examinations for duplication of and inconsistency with other state regulations, a public hearing and an appeals process.

Texas has several specialized programs in prevention. The Multiphasic Screening Program, Chronic Disease Division, provides screening tests, counseling and monitoring for hypertension, weight problems, vision screening, hearing screening, diabetes, anemia, several cancers such as cervical, prostate, oral and colorectal, self-breast cancer examination and pulmonary function testing for adults (16 years or over) in 5 Public Health Regions. The Diabetes and Hypertension Programs provide screening tests, counseling and monitoring for adults statewide.

The Venereal Disease Information and Education Program actively responds to all state agencies. Motivational messages are delivered to patients within clinic settings in an effort to promote improved voluntary health behaviors and encourage total treatment for infected persons and their sex partners. Informa-

tion, consultation and training are routinely provided to medical, school and agency personnel. Those requiring specialized VD Education services-- Spanish speaking, developmentally disabled, societally impaired, asymptomatic and high-risk (as identified by age, community, habits/lifestyles)--are reached through specific community education campaigns and communication methodologies. Electronic and printed media are used to reach the general public.

Provisions of vaccines for diptheria, pertussis, tetanus, polio, measles, mumps and rubella have been provided to all local, city/county and regional health departments. The infant Immunization Surveillance Program is utilized to encourage parents to have their children immunized early and completely by two years of age. This is a mail out program utilizing the computer with personal follow-up for non-responders and incompletely immunized children. An annual assessment is conducted of the immunization status of two-year-old Texas-born children and all individuals enrolled in licensed child-care facilities, public and private schools.

The state has allocated substantial funds to preventive joint state-federal programs. Independent state programs on prenatal and postnatal care received $205,000 between 1978 and 1980 while cervical cancer detection received over $60,000 each year. The state program on TB screening and control also received over $6 million each year.

The Texas Department of Mental Health and Mental Retardation offers several programs to ensure the availability of non-institutional alternatives for the mentally and developmentally disabled principally through Community Mental Health and Mental Retardation Centers. The following are included:

1) Community support programs to develop a network of services,
2) Fairweather lodges for deinstitutionalized clients,
3) Foster Homes and Cooperative, and
4) Case management through the Liaison Worker Program.

In 1979, state expenditures for small group homes (operated and subsidized by the state) for the mentally disabled were in excess of $6.7 million. The state allocated substantial funds to joint state-federal efforts in deinstitutionalization.

## UTAH

Health care cost containment is coordinated by the Governor's Planning Office and health and welfare programs coordinated by the Human Resources Cabinet.

Benefit package, medigap benefits and cancer insurance offered by Blue Cross/Blue Shield, health maintenance organizations and commercial carriers are subject to the commissioner's approval. Premium rates also require approval but those offered by HMO's are checked only for adequacy while only individual policies' premium rates of the commercial carriers need approval.

The rate-setting program in Utah applies only to Medicaid programs. The services include nursing homes, home health and some categories of ambulatory care. The cost of running the programs totalled $67.03 million in 1978, $86.1 million in 1979 and $87.5 million in 1980. Costs in 1981 are estimated to be $102.9 million.

To monitor bed construction and capital investments compliance with the CON program, quarterly progress reports are required from all CON recipients. Sanctions which can be applied against CON violators are a fine and/or injunctive relief. The CON program also covers outpatient hospital services and specific diagnostic or therapeutic equipment regardless of location. Applications to the CON program are currently grouped together for consideration.

Utah has also adopted on a demonstration basis a swing bed policy, shared or regionalized services among facilities, consolidation into the HSA health plan of other categorical health plans and formation of other multiple organizational units.

Utah has no laws mandating disclosure of information on hospital room charges,physician and non-physician practitioner fees, drug costs, HMO and other insurance plans or the qualifications of health personnel. However, no difficulty has been experienced in obtaining such information. The Utah Health Cost Management Foundation, sponsored by the state legislature and the Department of Health, intends to publish rates in a comparative study. There are no restrictions on advertising of physician, dental and psychiatric care fees, nonphysician practitioner fees, drugs, etc.

Utah has adopted coordination between licensure, accreditation and certification surveys for hospitals, nursing homes and rural health clinics. Technical assistance programs for licensure of hospitals, nursing homes and rural health clinics have also been implemented as well as the phasing-in of requirements. The evaluation of safety code requirements for health care facilities includes examination for inconsistency with other state codes or regulations and an appeals process.

Although no master plan is being used, Utah provides support to hospital residents to encourage practice in rural health settings. Since FY 1978, $20,000 has been provided annually to medical students which did not require a payback in service.

Nurse midwives, family nurse practitioners nurse psychotherapists and physician assistants are licensed to practice in Utah. The State Board of

Nursing regulates nurse practitioners and psychotherapists, physician assistants are regulated by the State Board of Medical Examiners and another state agency regulates nurse midwives. Physician assistants are supervised by a physician who is physically present and nurse midwives and nurse psychotherapists through written protocols. Nurse midwives and nurse psychotherapists have been granted some authority to administer and prescribe drugs while physician assistants may only administer drugs. As of FY 1980 an estimated 40 nurse midwives and 130 nurse practitioners will be licensed in Utah.

The Bureau of Health Promotion and Risk Reduction coordinates state efforts on health promotion and disease prevention. The mission of the bureau is threefold: 1) to promote the concept of good health and wellness by informing the general public about health enhancing practices and making them aware of the resources to do so; 2) to provide technical assistance and in-service training for health education and health promotion to all local health departments in Utah; 3) to eliminate unnecessary duplication of prevention services by coordinating a statewide prevention network.

Faced with a steady increase in nursing home expenditures the Utah state legislature commissioned the Utah Department of Social Services to explore alternatives to nursing home care for the elderly. The project was undertaken by the Division of Aging. One important finding of the Division is that approximately 40% of admissions occur for social, as opposed to medical reasons. Social reasons were defined as inability or unwillingness of the family to provide care, personal choice or the person living alone. A broken bone, terminal illness, nursing care requirements or rehabilitation therapy were defined as medical reasons. Admissions to nursing homes based on social reasons were considered to be inappropriate or premature by the Division of Aging in addition to being very expensive. The study also found that a lack of programs to provide in-home services and a lack of information about available services contributes to inappropriate/premature placement in nursing homes. As a result, Utah created The Alternatives Program (TAP) to minimize admissions based on social reasons and to more effectively utilize state monies. Services provided under the program include home health, meals on wheels and homemaker services. The first goal of TAP in the first year was to achieve a 12% reduction in nursing home admission, which was exceeded. At the same time, the costs of keeping the residents in the community were less than if they had been institutionalized.

Utah's contribution in 1980 to joint state-federal programs such as home health for the elderly reached $1.5 million, up from $292,698 in 1978, and for independent state home health programs the state allocated $400,000 for the elderly, and $100,000 each for the mentally disabled and developmentally disabled also in 1980.

During 1980 other joint state-federal alternative programs for the mentally disabled such as homemaker and other chore services received $1.7 million, congregate living services $4.9 million, day care health and social services $5.8 million, foster care $4.9 million and transportation services $5.7 million. All allocations are the state's contributions to joint state-federal programs. State institutions for the mentally disabled also received $19.7 million in state funds in 1980. Utah has also established 3 boarding homes and 23 small group homes, under 16 beds, for the mentally disabled. State subsidy for operation of the boarding homes is $9 per day per client. Four of the small group homes are owned by the state. State subsidy for operation of the group homes totals $428,980 and $228,000 has also been provided as state loans or direct assistance. The group homes contain 8 or less persons and the boarding homes 16 or less.

## VERMONT

The State of Vermont does not have a current hospital rate-setting or budget review system nor is one proposed. However, a nursing home rate-setting committee has been established to administer contracts with nursing home facilities and state social welfare programs. This committee has developed a system of prospective reimbursement.

Benefit packages and premium rates offered by Blue Cross/Blue Shield, health maintenance organizations and all commercial carriers are subject to the insurance commissioner's approval. In addition, the state prescribes minimum standards for medigap policies, including the provision of an outline of coverage to the insured and cancer insurance.

To ensure compliance with the Certificate of Need program the Health Department may investigate. In cases of violation sanctions which can be applied include a fine, suspension or revocation of licensure, denial of reimbursement and denial of licensure. Outpatient hospital services and clinic services are also covered under the program. The State of Vermont has no laws or regulations restricting or requiring the provision of rate or qualification information to the public on health services or personnel.

The Vermont State Assistance Corps provides support to medical students nursing and nurse practitioner programs. A breakdown of financial assistance according to profession was not available. Approximately 19% of all state funds for the University of Vermont are targeted to the medical school.

Physician assistants are registered to practice in Vermont by a state agency. They are prohibited from administering drugs. In 1980, 55 PAs were registered for practice in the state. Nurse practitioners including nurse midwives, nurse psychotehrapists, etc. are licensed as RNs only.

For hospitals, interchangeable state licensure, voluntary accreditation and certification standards have been adopted. Other types of coordination between licensure, accreditation, and certification surveys have also been adopted for hospitals, nursing homes and rural health clinics. Nursing homes also have technical assistance programs for licensure. The safety code evaluation for health care facilities includes an examination for duplication of and inconsistency with other state codes and regulations as well as an appeals process.

Between 1978 and 1980 the state has provided a minimum of $35,000 each year for prenatal and postnatal care and over $14,000 for perinatal care for joint state-federal programs. Venereal disease control has received over $107,000 each year and TB screening and control over $140,000. Funds for communicable disease control rose from $36,000 in 1978 to $91,000 in 1980 and for immunization from $60,000 to $80,000 over the same period. In 1980 early and periodic screening and diagnostic testing was allocated $380,000. Over the three years children and youth health projects rose from $145,000 in 1978 to $150,000 in 1979 and then declined to $134,000 in 1980.

Non-institutional care initiatives have focused on the provision of homemaker and other chore services to the state's elderly population (financial

support for joint state-federal programs exceeded $325,000 for each of the last three fiscal years). The state is also actively developing community residential placements for mentally ill and developmentally disabled clients including supervised apartments, ICFMR and group homes. State support for development of these programs exceeded $1.4 million in FY 1980. Vermont will open 6 small group homes in 1981 funded by the HHS/HUD demonstration project.

# VIRGINIA

The Secretary for Human Resources is responsible for coordinating health care cost containment policy and state health and welfare programs.

The Virginia General Assembly enacted a hospital budget review program in 1978. The 1979 General Assembly increased the size of the Virginia Health Services Cost Review Commission from 9 to 11 members by the addition of two consumer members. Virginia's State Health Plan 1979-1983 urges the General Assembly to consider the merits of including nursing homes in the state budget review program.

To ensure compliance with the Certificate of Need program, an applicant must have a COPN or be determined to be exempt from COPN requirements before the facility or program can be licensed. To deal with violations sanctions such as jail sentence, fine, suspension of license, denial of reimbursement, denial of licensure and a court injunction may be applied. In Fiscal Year 1978 a court injunction was used once. The CON program also covers outpatient hospital services, clinic services, and diagnostic or therapeutic equipment. Only major medical equipment and scanners located in a physician's office are considered and physician's offices are excluded from review as long as service rendered is primary health service. Applications to the program are grouped if the projects can be considered in the same review cycle, otherwise they are considered on a first come first served basis. In the future, however, proposals will be grouped in same fashion as a result of federal regulations for batching.

Existing law requires the insurance commissioner to approve benefit package offered by health maintenance organizations and the composition of or appointment to the board of trustees of Blue Cross/Blue Shield. Regulations are currently being written to address the premium rates and medigap benefits of Blue Cross/Blue Shield and commercial carriers as well as the benefit package and cancer insurance of the latter insurance group.

Interchangeable state licensure, voluntary accreditation and certification standards have been adopted for hospitals. Other type of coordination between licensure, accreditation and certification surveys have also been adopted for both hospitals and nursing homes.

Virginia has adopted a loan program with payback provisions both to aid medical students and to provide medical personnel for areas suffering from a shortage of medical personnel. An estimated 58 recipients will have enrolled annually in the program between 1978 and 1981. Recipients must practice family medicine in an area of need in Virginia; the terms 'area of need' and 'family medicine' defined by the State Board of Health. Full-time employment with the State Department of Health, Mental Health and Mental Retardation, Welfare and Corrections is also an approved payback method. Failure to practice as specified requires momentary repayment of the scholarship at 10% interest from date of contract. (Since the program's inception in 1942, more than half of the recipients have bought out of the program.)

Virginia regulations allow nurse midwives, family nurse practitioners and physician assistants to practice in the state. Nurse midwives are regulated by the State Board of Nursing and the State Board of Medical Examiners; physician assistants are regulated by the latter board. Both nurse specialists are supervised by written protocols and physician assistants by a physician on the

premises. The dispensing and prescribing of drugs by nurse midwives and family urse practitioners are prohibited. Physician assistants are prohibited from prescribing drugs. A total of 17 nurse midwives, 81 family nurse practitioner and 150 physician assistants have been licensed between 1978 and 1980.

Joint state-federal preventive health programs such as prenatal and postnatal care received over $1.1 million each year between 1978 and 1980. Venereal disease control received a total of $385,000 between 1979 and 1980. Children and youth health projects received an annual average of $3.6 million in 1978, 1979 and 1980. Independent state programs on cervical cancer detection were allocated a total of $655,000 for 1979 and 1980 and TB screening and control an annual average of $842,000 while PKU testing received $47,000 each year.

Virginia has implemented a number of programs to provide service alternatives to institutionalization. Home health service in 1980 for the elderly received $561,214 in state contributions to joint state-federal programs and $8.3 million in state funds while the mentally disabled received $384,290 from the state for joint efforts. Homemaker and chore services for the elderly received $325,546 in state funds to joint programs and the developmentally disabled $86,354 also in state funds to joint programs in 1980. The state provided $2.4 million for congregate living services for the mentally disabled in 1980 while $117,967 were contributed to joint programs for the developmentally disabled for the same services. Day care health and social services for the elderly received $212,074 also in state funds to joint programs and for the mentally disabled $1.6 million was allocated. Ancillary services such as case management for the developmentally disabled received $124,875 in state funds to joint programs and for the mentally disabled the state allocated $1.3 million to independent state programs. Transportation, another ancillary service, received $1.94 million state funds to joint programs for the elderly while the state allocated $140,843 for the mentally disabled in independent state programs.

In addition, the state will begin to expand community Medicaid intermediate care facilities' coordination of patients discharged from state facilities. An annual allocation of $1 million will be provided through the 1980-82 Appropriations Act. The Virginia Department of Rehabilitation Services has developed an Independent Living Center and a Community Rehabilitation Services System, which includes community education, rehabilitation engineering assistance, and vocational evaluation services.

For the mentally disabled, a total of 104 small group homes have been established. The state subsidy for the operation of these facilities is $.6 million. State loans for the renovation of facilities are $41,000.

## WASHINGTON

State health and welfare programs are coordinated by the Department of Social and Health Services. The state has a model hospital rate-setting program.

To monitor compliance with Certificate of Need, the program is now developing a mechanism to monitor authorized bed construction and capital expenditures. In cases of violation a fine or a court injunction may be imposed on the violators. The program also covers outpatient hospital services and CT scanners. Proposals to the program are currently considered on a first come first served basis but will be grouped together in the future. The state has also adopted shared or regionalized services among facilities on a demonstration basis.

The insurance commissioner must approve benefit packages, premium rates, and medigap benefits offered by Blue Cross/Blue Shield, health maintenance organizations and other commercial carriers as well as cancer insurance policies offered by the commercial carriers.

Washington has also adopted coordination between licensure, accreditation and certification surveys for hospitals, nursing homes and rural health clinics as well as technical assistance programs for licensure of hospitals and nursing homes. The safety code evaluation of health care facilities includes an appeals process for codes and regulations.

The Hospital Commission publishes a semi-annual price report which is a public document. In addition, physicians, physician assistants, nurses and pharmacists, etc. must be licensed by the state and the information is a public record. The state has applied restrictions to advertisement of physician fees.

Physician assistants are licensed to practice in Washington and are under the auspices of the State Board of Medical Examiners. They are supervised by telecommunication and by the physician on the premises. Some authority to prescribe, dispense and adminster drugs has been granted. A total of 230 physician assistants were licensed in 1980.

The Bureau of Aging funds several grant programs for the state's elderly including an Information and Assistance Program to provide workers in the aging network to manage a service plan for the multi-problem clients aged 60 and over.

The state also supports a Residential Pre-placement Screening Program to determine the relative need for community services versus residential care. Both programs are funded through several sources. The state Senior Citizens Services Act provides a wide range of programs aimed at preventing premature or unnecessary institutionalization. Nutrition programs and access services, including transportation, information and assistance, and others are available free of charge or on a donation-only basis. A few programs offered through SCSA have a sliding fee scale. Some programs are not available on a statewide basis due to differences in local priorities for use of funds.

For the developmentally disabled, the state allocated $241,500 for homemaker services, $6.8 million for congregate and community residential services, $519,500 for case management and $6 million for day care in 1980. Washington also contributed to joint state-federal efforts for home health aids and case management.

## WEST VIRGINIA

In January 1979 West Virginia enacted a budget review program for hospitals. The program is a disclosure system and covers Blue Cross, Medicare, Medicaid, commercial payors and individual payors. Administration of the program is through the existing State Health Planning Agency. Budget review of hospital expenditures is conducted annually.

The approval of the commissioner of insurance is required for benefit packages, premium rates, medigap benefits and cancer insurance offered by Blue Cross/ Blue Shield, health maintenance organizations and commercial carriers. The composition of or appointment to the board of trustees of health maintenance organizations also requires the commissioner's approval.

To assure compliance with bed construction and capital expenditures authorized by the Certificate of Need program recipients of CON's are required to have a 'conformance review' upon completion of the project and prior to actual offering of the new services. In 1979 one instance of non-compliance was detected. Sanctions which may be imposed for violation of the CON are revocation of license, denial of licensure and an injunction. Covered under the Certificate of Need program are outpatient hospital services and clinic services. Diagnostic or therapeutic equipment is also proposed for coverage. Applications to the program are currently considered on a first come first served basis but will be grouped as required by federal law. The state has adopted on a demonstration basis the consolidation of the HSA health planning process with planning activities for other categorical health programs into a single process and the consolidation into the HSA health plan of other categorical health plans. Formation of other multiple organizational units have also been adopted on a demonstration basis. Aside from the financial disclosure required by the budget review process, no other laws exist in the state which mandate or restrict advertising.

To aid in health manpower development West Virginia provided $10.7 million, $11.9 million and $12.9 million in 1978, 1979 and 1980, respectively, to medical student programs. Residency programs received $825,000, $883,000 and $945,000 over the same three-year period. Of this amount a substantial portion was targeted on community and family medicine and general practice residencies, amounting to 60.6% in 1978, 74.5% in 1979 and 83.8% in 1980. Direct financial assistance over the same three years to physician assistants totalled $66,000 and to registered nurses $82,000. None of this assistance required the repayment of obligation by performing services within the state.

Physician assistants are licensed to practice in West Virginia and are regulated by the State Board of Nursing. They are supervised by a physician and are prohibited from prescribing or dispensing drugs.

Coordination between licensure, accreditation and certification surveys have been adopted for hospitals and nursing homes. Technical assistance consultation for licensure of hospitals and nursing homes is also provided as feasible. The safety code evaluation of health care facilities includes an examination for inconsistency with other state regulations, public hearings and an appeals process.

Joint state-federal programs on health promotion and disease prevention such as prenatal and postnatal care received state funds totalling $1.7 million in 1978, $2.6 million in 1979 and $3.0 million in 1980. Funds for immunization increased from $70,000 in 1978 to $241,000 in 1980, early and periodic screening and diagnostic testing rose from $592,000 in 1978 to $774,000 in 1980 while hypertension funds increased from $109,000 to $155,000 over the same period. Over the same three years, venereal disease control received an annual average of $190,000, cervical cancer detection $76,000 and PKU testing $53,000. Independent state programs on TB screening and control averaged $458,000 annually. Hypothyroid testing received $50,000 in 1979 and again in 1980.

## WISCONSIN

Health care cost containment is coordinated by a staff member of the executive office of the Governor who also coordinates other health policy issues. The Wisconsin hospital rate setting program was created in October 1976 and has not been significantly changed since then.

The insurance commissioner approval is required for all carrier benefit packages including special requirements for medigap and cancer policies. State statute specifies requirements for board composition. Benefits offered by HMOs must also be approved.

In Wisconsin, notification by the licensing agency and fiscal intermediaries regarding potential violations of CON law contributes to the process of monitoring bed construction and capital expenditures. Sanctions which may be imposed on violators include a fine, suspension or revocation of license, denial of reimbursement and denial of licensure. Outpatient hospital services are covered by the CON. Clinic services and physician office services are also covered if they contain equipment whose cost exceeds $117,000. Applications to the CON program are currently considered on a first come first served basis but will be grouped in the future. The program has a mechanism to decertify beds if they are not needed by the community or if the institution is incapable of maintaining the service. The state has also, on a demonstration basis, consolidated the HSA health planning process with planning activities for other categorical health programs.

To coordinate health service needs with decisions on financial assistance to medical programs the Medical Education Review Committee assesses graduate medical education with respect to number of students, specialty emphasis, types and locations of residency programs, retention of graduates and distribution of physicians, and reports findings to the Joint Finance Committee of the Legislature which then recommends legislative or budgetary changes. The Enabling Committee of the Health Policy Council also assesses health manpower needs in the state, develops policies, initiates legislation and recommends funding levels to the Governor. Legislation has been enacted to create a Medical Student Loan Forgiveness Program but has not yet been implemented. The program involves no penalty but it does offer loan forgiveness for service in an area experiencing medical manpower shortages. The state is also proposing to create a state mental health service corp for the field of psychiatry. State support would augment federal stipends for training of psychiatrists. No payback requirement is included. The state has provided $17.1 million in 1978, $19.0 million in 1979 and $20 million in 1980 to medical student programs, including residencies. Additional funds were allocated to community and family residency and general practice programs totalling $2.3 million, $2.8 million and $3.1 million over the same three years. The state regulates residency programs to the extent that every residency affiliation must be approved by the Medical Education Review Committee. The state also provided $101,000 between 1978 and 1979 to colleges, universities and affiliated hospitals for the education of physician assistants. A total of $15.6 million was provided for the education of family nurse practitioners and registered nurses between 1978 and 1980.

Nurse midwives, family nurse practitioners, and nurse psychotherapists are licensed as RNs. Physician assistants are licensed as a separate category to practice in Wisconsin. The nurse specialists are regulated by the State Board

of Nursing and physician assistants by the State Board of Medical Examiners. Supervision for nurse midwives is by written protocol, for family nurse practitioner by general or special supervision of the physician and for physician assistants by the physician on the premises or through telecommunication. Nurse midwives and nurse practitioners are granted permission to administer drugs in an emergency and requires the physician's name to appear on the prescription. Physician assistants are prohibited from prescribing, dispensing and administering drugs. In 1978 approximately 10 nurse midwives and 20-30 nurse practitioners were practicing in these areas. For physician assistants, a total of 255 were licensed in 1980.

The Wisconsin Commission on Prevention and Wellness was created in 1977 to advise the Department of Helth and Social Services on how to best promote health and focus more resources on preventing physical, mental and social ills in the state. Approximately $980,000 in General Purpose Revenues were appropriated to provide seed funding for a statewide prevention and wellness demonstration grant program. Nine projects were funded through this program. Although the funding was not renewed by the State Legislature and the Commission was phased out in October 1979, the work of the Commission is now carried on through the Statewide Health Policy Council's Committee on Prevention, Detection and Health Promotion. In addition, the Secretary of the Department of Health and Social Services has established Planning Guidelines for Health Protection and Promotion, which will provide direction for the Department from 1979 to 1983. The state has also provided a total of $94,000 for joint state-federal programs on perinatal care between 1978 and 1980 and the same sum for venereal disease control. Sums provided to the joint communicable disease control program increased from $5,000 in 1978 to $10,000 in 1980, from $64,000 in 1978 to $150,000 in 1980 for early and periodic screening and diagnostic testing. Nutrition education received an annual average of $20,000, immunization an average of $6,700 and hypertension screening an average of $25,000 over the same three years. Independent state programs on cervical cancer detection, kidney disease aids and TB screening and control received a total of $462,000, $3.6 million, and $462,000, respectively, from 1978 to 1980. Sudden infant death syndrome received a total of $34,000 from 1979 to 1980.

Wisconsin provided $3.3 million in 1980 and will provide $4.5 million in 1981 as capacity funds for community support programs in 45 of the state's 72 counties. The CSP program provides outreach coordination with other community agencies, independent living, skill training, etc. In addition, the state provided over $5 million in independent congregate living service programs for these client groups. The state also participates in several other innovative programs for elderly, mentally and developmentally disabled client groups. These include:

1) Residential Services project for the Developmentally Disabled designed to build living resources; and
2) Case Management Service Coordination Project which mandates all counties to plan a system for the case management of all clients with a long-term recurring need, problem, illness or disability. The project, in part, is designed to meet needs of the multiply disabled.

A proposal is pending to fund ten respite care pilot projects for families of dependent individuals. Finally, Wisconsin participates extensively in joint state-federal efforts to provide day care services, home health services, congregate living, homemaker, case management and transportation services.

# WYOMING

The Wyoming Certificate of Need program includes a mechanism to monitor authorized bed construction and capital expenditures. Sanctions which may be imposed in cases of violation are jail sentences, a fine, revocation of license and denial of licensure. Outpatient hospital services and clinic services are also covered by the CON program and diagnostic or therapeutic equipment is proposed for coverage. Applications to the program are currently considered on a first come first served basis.

The insurance commissioner's approval is required for benefit packages, premium rates, medigap benefits and cancer insurance offered by Blue Cross/Blue Shield and commercial carriers. Approval is based on the relationship of benefits to the premium.

Simultaneous inspection of hospitals by state surveyors and the Joint Commission for the Accreditation of Hospitals is under discussion with the JCAH. Technical assistance programs for licensure of hospitals, nursing homes and rural health clinics have been adopted. The safety code evaluation of health care facilities includes an examination for duplication of and inconsistency with other state codes and regulations, cost-benefit analyses, public hearings and an appeals process.

Dental fees for professional service may not be advertised in Wyoming. Drugs for treatment of venereal disease, sexual dysfunction, or to procure an abortion or miscarriage also cannot be advertised. Wyoming has no laws which require advertising of information. At one time a voluntary listing of room charges and physician fees was made available by the state hospitl association.

Physician assistants are licensed to practice in Wyoming and are regulated by the State Board of Medical Examiners. Supervision is by written protocol and they may dispense or administer durgs on the orders of a physician. A total of 30 physician assistants will be licensed in 1980.

Between 1978 and 1980, Wyoming has allocated funds to joint state-federal preventive health programs on venereal disease control, TB screening and control, communicable disease control, immunization and early and periodic screening and diagnostic testing totaling $16,000, $48,000, $611,000, $72,000 and $39,000, respectively.

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